

Enriching Lives by Exceeding Expectations

General Health

Name: _____

Are you in good health? YES ___ NO ___

Are you currently under the care of a physician? YES ___ NO ___

If yes, please explain: _____

Physician's name: _____

Phone: _____

Please list all the medications currently being taken:

Do you smoke or use tobacco in any form: YES ___ NO ___

WOMEN ONLY: Are you pregnant? YES ___ NO ___ Due date _____

Are you nursing? YES ___ NO ___

Are you using birth control pills? YES ___ NO ___

Have you ever had any of the following? Please circle each one.

Heart Trouble	Y	N	Stroke	Y	N
High Blood Pressure	Y	N	Joint Replacement	Y	N
Rheumatic Fever	Y	N	Diabetes	Y	N
Heart Murmur	Y	N	Hepatitis	Y	N
Mitral Valve Prolapse	Y	N	HIV/AIDS	Y	N
Artificial Heart Valve	Y	N	Sinus Problems	Y	N

ARE YOU ALLERGIC TO OR REACTED ADVERSELY TO:

Local Anesthetic	Y	N	Aspirin	Y	N
Penicillin	Y	N	Codeine	Y	N
Sulfa Drugs	Y	N	Latex	Y	N

Is there anything additional you feel is important for us to know about your health?

Dental Health

Why have you come to the dentist today? _____

Many patients come to us for a second opinion or cosmetic treatment only. Are you currently seeing another dentist for your dental needs?

YES ___ NO ___ If yes, please explain: _____

How would you describe the condition of your teeth?

Good ___ Fair ___ Poor ___

How would you describe the condition of your gums?

Good ___ Fair ___ Poor ___

Are you currently having pain or discomfort in your teeth or gums?

YES ___ NO ___ If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? YES ___ NO ___

When you floss? YES ___ NO ___

Are you concerned about bad breath? YES ___ NO ___

Have you ever had a problem with your jaw (TMJ) joint?

YES ___ NO ___ If yes, please explain: _____

Do you clench or grind your teeth while awake or when asleep?

YES ___ NO ___

If yes, do you have a bite appliance or nightguard? YES ___ NO ___

How often do you wear it? _____

If you had a magic wand, what would you change about the appearance of your teeth?

I understand that, to the best of my knowledge, the questions on this form have been accurately answered. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or condition.

I authorize the dental staff to perform all necessary dental procedures that I may need with my informed consent. I also give permission to the doctor or his staff to use any photos he may take to be used for lecturing, publishing, or educational purposes.

Signature _____ Date _____

This area for doctor's notes

Please do not write below this line

Welcome...



We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we can provide the best care possible for you. Thank you!

Brian McKay, DDS & Team

Dental History ~

What prompted you to call our office for an appointment? _____

When was the last time you were seen by a dentist? _____

Previous dentist's name? _____

Did you have regular dental care as a child? Y N

As a child, did you have a lot, average, or very little tooth decay? _____

Do you have any dental anxieties? If so, what is the origin of your anxiety? _____

Has a dental office ever helped you set up a treatment plan? _____

As you come into a new dental practice, what are your expectations, concerns, and or/priorities? _____

Dentally, what would you like to achieve? What does the "finish line" look like? _____

If you could wave a magic wand and change anything about the appearance of your smile, what would you like to do? _____

Guided Tour Through Your Mouth ~

Have you had cosmetic dentistry (eg. Bonding, Veneers)? _____

Periodontal Screening ~

Have you ever had..... Pocket measurements? Y N Bone loss evaluation? Y N
 Have you ever been treated for periodontal disease? Y N Root Planing? Y N
 Do you suspect that you have mouth odor? Y N
 Have you noticed any loosening or mobility of your teeth? Y N
 Do you suffer from pain and/or swelling of your gums, or have any pus around your gums? Y N

Habits ~

Do you... Clench your teeth during the day? Y N Grind your teeth at night? Y N
 Bite your lips or cheeks regularly? Y N Sleep with your mouth open? Y N
 Chew tobacco or snuff? Y N Smoke cigarettes? Y N
 Hold foreign objects with your teeth (pencils, etc.)? Y N

Problems of the Jaw ~

Have you ever been treated for TMJ? Y N
 Have you ever experienced: Clicking of the joints? Y N Pain? Y N
 Difficulty chewing? Y N Locking? Y N
 Chronic neck or shoulder pain? Y N Chronic headaches? Y N
 Morning headache? Y N Migraine headache? Y N

Please share with us any additions thoughts, comments, or concerns regarding your dental experiences or expectations ~

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Name _____

Date _____



Quality of sleep is very much related with oral health and overall wellness.

Please answer these few questions regarding your sleep patterns.

How likely are you to fall asleep in certain situations?

Please circle the answer that applies best to you

SITUATIONS	CHANCE OF FALLING ASLEEP			
	<i>Would Never</i>	<i>Slight</i>	<i>Moderate</i>	<i>High Chance</i>
a) Sitting and Reading	0	1	2	3
b) Watching TV	0	1	2	3
c) Sitting inactive in a public place (theater or meeting)	0	1	2	3
d) Riding as a passenger in a car for more than 1 hour	0	1	2	3
e) Lying down to rest in the afternoon when time permits	0	1	2	3
f) Sitting and talking to someone	0	1	2	3
g) Sitting quietly after lunch (without alcohol)	0	1	2	3
h) In a car, while stopped for a few minutes in traffic	0	1	2	3

Tell Us About You...



The better we understand you, the better we can serve you. Please make a mark along each scale below to indicate your opinion or preference.

<i>I know a great deal about my dental condition</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I know very little about my dental condition</i>
<i>I like to be presented with fewer options</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I like to be presented with more options</i>
<i>I tend to look at the details</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I tend to look at the big picture</i>
<i>I prefer long lasting solutions which may initially cost more</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I prefer temporary solutions at lower cost</i>
<i>I prefer to talk in technical terms with my dentist</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I prefer to talk in non-technical terms</i>
<i>My insurance largely determines the extent of my care</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I largely determine the extent of my care</i>
<i>I prefer to wait until I must act</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I usually see no reason to delay care</i>
<i>I rely more on self-maintenance</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I rely on more professional maintenance</i>
<i>I like newer and more modern techniques</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<i>I like tried and true methods</i>

In order of importance, I generally consider the following **benefits** (Please rank 1 through 7 or 8):

Comfort
 Function
 Health
 Appearance
 Precision
 Peace of Mind
 Durability
 Other _____

In order of importance, I generally weigh the following in making a decision regarding my dental health (Please rank 1 through 5 or 6):

Money
 Time
 Personal Effort
 Physical Discomfort
 Fear/Anxiety
 Other _____