SCOTT DENTISTRY

WELCOME

To help us meet your dental needs, please complete this form. We appreciate your cooperation in giving us thorough and accurate information. If you have any questions or need assistance, please let us know. Thank you.

Name: _____ Preferred Name: _____ Age: _____

Birth Date:_____ ( ) Male ( ) Female Social Security #:_____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Employer/School: _____

Phone#: Home: _____ Work: _____ Mobile/Pager: _____

Responsible Party Information

Name: _____

Address: _____

Phone: _____

Employer: _____

Emergency Contact: _____

Phone: _____

Insurance Information

Policy Holder's Name: _____

Policy Holder's S.S. or I.D.#: _____

Policy Holder's Date of Birth: _____

_____

Policy Holder's Employer: _____

Insurance Co. Name: _____

How were you referred to our office? _____

Authorization and Release

Payment and Insurance

I authorize Dr. Scott or his employees to release any information concerning my own dental treatment or my child's dental treatment to third party payers (insurance companies) and/or health practioners. My signature below allows payment from third parties to be sent directly to Scott Dentistry. I understand that payment is due at the time of service unless other arrangements have been made, and that I am ultimately responsible for the entire fee of all services rendered.

Photography and Documentation

In our office we photograph our patients for aid in determining their problems and to help develop customized treatment plans. Dr. Scott also uses the photographs, with the patient's permission, to teach other dentists. We are very proud of the work we have done and only publish photographs of our own patients in our marketing and advertising. I authorize Dr. Scott to take photographs, slides, and/or videos of my face, jaws and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: _____ **Date:** _____

Personal Medical History

Name: _____

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Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes:_____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes:_____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes:_____

Are you taking any medications, pills or drugs? ○ Yes ○ No If yes: _____

Do you take, or have you taken Phen-Fen or Redux? ○ Yes ○ No If yes:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes:_____

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use a controlled substance? ○ Yes ○ No If yes:_____

Women: Are you: ○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex

○ Sulfa drugs ○ Local Anesthetics ○ Other:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Anemia	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Angina	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Glaucoma	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Hay Fever	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Asthma	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Blood Disease	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Rheumatism	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Shingles	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Hemophilia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Chest Pains	○ Yes ○ No	Herpes	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Stroke	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Convulsions	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cortisone Medication	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Tonsilitis	○ Yes ○ No
Diabetes	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Drug Addiction	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Easily Winded	○ Yes ○ No	Leukemia	○ Yes ○ No	Ulcers	○ Yes ○ No
Emphysema	○ Yes ○ No	Liver Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Epilepsy/Seizures	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Lung Disease	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature:_____ Date:_____

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Personal Dental History

Name: _____ What name would you like us to call you?_____

Do you have a specific dental problem at this time? If so, explain _____

Have you ever had any serious trouble associated with previous dental treatment? If so, explain: _____

_____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Date of last dental visit: _____ Dentist's name: _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea)? Yes No

Do you have or ever had the following?

Mouth

Bleeding, sore gums	Yes	No
Unpleasant taste, bad breath	Yes	No
Burning tongue/lips	Yes	No
Fever blister - lips / mouth	Yes	No
Swelling / lumps in mouth	Yes	No
Orthodontic treatments (braces)	Yes	No
Biting cheeks / lips	Yes	No

Jaw

Have you ever been diagnosed with a "TMJ" problem?	Yes	No
Does your jaw pop or click when when you open your mouth?	Yes	No
Are you aware of clenching or grinding your teeth?	Yes	No
Do you have pain or difficulty opening your mouth wide?	Yes	No
Do you have a history of headaches or neck aches?	Yes	No

Teeth

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction between teeth	Yes	No
Shifting of teeth	Yes	No
Change in bite	Yes	No
Black Triangles / Gum Recession	Yes	No

How often do you brush? _____

My toothbrush is: soft medium hard

How often do you floss? _____

What kind of floss do you use? _____

Have you / do you wear a nightguard? Yes No

Do you sleep with a CPAP? Yes No

or other snoring device? Yes No

Do you have a family history of:

☐ Heart Disease ☐ Heart Attack

☐ Stroke ☐ Diabetes

What do you drink throughout the day?: _____

_____

Describe daily snacks: _____

_____

What would you like to see done now? _____

_____

_____

What are some questions about dentistry and your dental health that you have never adequately had answered? _____

_____

_____

_____

_____

_____

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Your Dental Story

In order for me to completely evaluate your medical and dental problems, it is very important to have a thorough history of your issues. For instance, did you have orthodontic treatment? When and where, and what do you remember about it? Have you had any accidents involving your mouth, teeth or jaws? Tell me about your sleep quality, quantity and any sleep difficulties.

Name: _____ Date: _____

This, in a sense, is "your dental story." It is a detailed history of you and how you got to where you are today. That way we can plan the best treatment for your particular problems.

So, please tell me "your story"…_____

SCOTT DENTISTRY

Smile Analysis

This is your invitation to complete our smile analysis form. Your answers will bring to Dr. Scott's attention any treatment from which you feel you may benefit.

Name:_____ Date:_____

	Yes	No	Need more info
1. Are you satisfied with your teeth and their appearance?	○	○	○
2. Are you self conscious about your teeth when you smile?	○	○	○
3. Do you wish your teeth were whiter?	○	○	○
4. Do you wish your teeth were shaped differently?	○	○	○
5. Do you have any discolored teeth?	○	○	○
6. Do you wish your back fillings were tooth colored, not silver?	○	○	○
7. Do you have any old crowns which now show dark lines at the gums?	○	○	○
8. Do your gums appear red, swollen, or puffy when you smile?	○	○	○
9. Do you have a denture which is old and worn / fits poorly?	○	○	○
10. Do you have any missing teeth you would like to replace to improve your smile?	○	○	○

11. If you could alter your smile what would you change?

_____

_____

_____

12. On a scale of 1-10 how happy are you with your smile?

(10 = I love my smile and would'nt change anything)

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Patient Name:

_____

Date:_____

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Head and Neck Symptoms

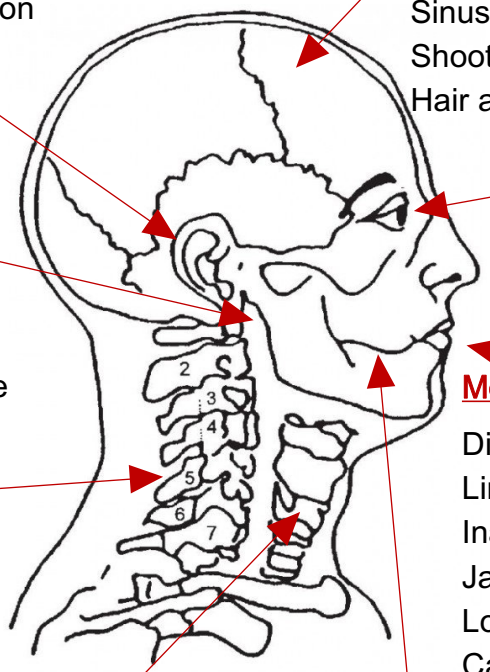
On the visual illustration below please circle the items that pertain to you.

Head Pain, Headache

Forehead
Temples
"Migraine" type
Sinus type
Shooting pain up back of head
Hair and/or scalp painful to touch

Ear Problems

Hissing, buzzing or ringing
Decreased hearing
Ear pain, ear ache, no infection
Clogged "itchy" ears
Vertigo, dizziness



Eyes

Pain behind eye
Bloodshot eyes
May bulge out
Sensitive to sunlight

Jaw Problems

Clicking, popping jaw joints
Grating sounds
Pain in neck muscles
Uncontrollable jaw and/or tongue movements

Mouth

Discomfort / Pain
Limited opening of mouth
Inability to open smoothly
Jaw shifts to one side when opening
Locks shut or locks open
Can't "find" a comfortable bite

Neck Problems

Lack of mobility, stiffness
Neck pain
Tired sore muscles
Shoulder aches and backaches
Arm and finger numbness and/or pain

Teeth

Clenching, grinding at night
Clenching, grinding during the day
Looseness and soreness of back teeth

Throat

Swallowing difficulties
Laryngitis
Sore throat with no infection
Voice irregularities or changes
Frequent coughing or constant clearing of throat
Feeling of foreign object in throat constantly

Now list the symptoms you've identified above in order of importance. Begin with the symptom which is the most painful or most concerning to you.

1._____ 4._____

2._____ 5._____

3._____ 6._____

Please update the following medical history. Name: _____

Name of medical doctor: _____ Last appt: _____

Please indicate if you have had any of the following:

Yes___No___Heart Attack
Yes___No___Stroke / TIA
Yes___No___Osteoporosis
Yes___No___High blood pressure
Yes___No___Diabetes
Yes___No___High Stress
Yes___No___Smoker past 3 years
Yes___No___Rheumatoid Arthritis
Yes___No___COPD
Yes___No___GI Disorders / IBS / Crohns

Yes___No___High carb diet
Yes___No___Lack of exercise
Yes___No___Pregnant now
Yes___No___Past miscarriage
Yes___No___Planning a family
Yes___No___Poor sleep quality
Yes___No___Snore
Yes___No___Have CPAP
Yes___No___Wear the CPAP
Yes___No___Periodontal Disease

Please indicate if any family history applies:

Has a parent or grandparent had heart disease, heart attack or stroke? Yes___No___
Has a parent or grandparent had diabetes? Yes___No___
Has a parent or grandparent had periodontal disease? Yes___No___
Has a parent or grandparent had cancer? type: _____ Yes___No___

The mouth is the gateway to health and wellness. Research shows that infection in the mouth is linked to higher risks of heart disease, diabetes and other systemic diseases. As advocates for your overall wellness, we will be checking the following **healthy mouth indicators.**

Healthy Gums/Soft Tissues	Healthy Teeth	Healthy Habits
Pink, firm gum tissue	No white spots or areas of demineralization	Brush 2x day
No tartar or plaque	No open decay	Floss or use interdental brush daily
No bleeding	No tooth loss due to erosion, abrasion or grinding	Limit quantity and frequency of sugar containing foods and drinks
Gum pockets 3mm or less	No sensitivity to hot, cold or sweet foods/drinks	Smoke-free
No gum recession	Pain-free	Fresh breath
No loose teeth	Good alignment of teeth and jaw joints	No dry mouth
No plaque traps or difficult to clean areas		Use antibacterial mouthwash
Control the side effects of medications/systemic dis		
No oral lesions/mouth sores		