Paper Mill Dental, LLC

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 help 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!

About The Patient

Name (first, MI, last) _____

How would you like to be addressed? _____

How did you hear about Us? _____

Home Address _____

City / State / Zip _____

Day Phone _____

Evening Phone _____

Mobile _____

Email _____

Birth date _____

Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐

Social Security No. _____

Emergency Contact Name/No. _____

Patient

Occupation _____

Employer _____

Address _____

Phone _____

Your Spouse/Guardian

Name _____

Occupation _____

Employer _____

Address _____

Phone _____

Dental Insurance

Primary Insurance Company _____

Insurance Phone No. _____

Group No. _____

Employer _____

Address _____

Insured's Name _____

Ins ID No _____

Insured Social Security No. _____

Insured's Birth Date _____

Relationship to Patient _____

Medical History

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	*YES*	*NO*
1. Hospitalization for illness or injury	☐	☐
2. An allergic reaction to		
☐Aspirin, ibuprofen, acetaminophen, codeine		
☐Penicillin		
☐Erythromycin		
☐Tetracycline		
☐Sulpha		
☐Local anesthetic		
☐Fluoride		
☐Metals (nickel, gold, silver, _____)		
☐Latex		
☐Other _____		
3. Heart problems, or cardiac stent within the last six months	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)	☐	☐
6. Pacemaker or implantable defibrillator	☐	☐
7. Artificial prosthesis (heart valve or joints)	☐	☐
8. Rheumatic or scarlet fever	☐	☐
9. High or low blood pressure	☐	☐
10. A stroke (taking blood thinners)	☐	☐
11. Anemia or other blood disorder	☐	☐
12. Prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. Emphysema, sarcoidosis	☐	☐
14. Tuberculosis	☐	☐
15. Asthma	☐	☐
16. Breathing or sleep problems (i.e. snoring, sinus)	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid, parathyroid disease or calcium deficiency	☐	☐
21. Hormone deficiency	☐	☐
22. High cholesterol or taking statin drugs	☐	☐
23. Diabetes (HbA1c =_____)	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Digestive disorders (and/or gastric reflux)	☐	☐
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. Arthritis	☐	☐
28. Glaucoma	☐	☐
29. Contact lenses	☐	☐
30. Head or neck injuries	☐	☐
31. Epilepsy, convulsions (seizures)	☐	☐
32. Neurologic problems (attention deficit disorder)	☐	☐
33. Viral infections and cold sores	☐	☐
34. Any lumps or swelling in the mouth	☐	☐
35. Mouth Ulcers, Fever Blisters	☐	☐
36. Hives, skin rash, hay fever	☐	☐
37. Venereal disease	☐	☐
38. Hepatitis (type ___)	☐	☐
39. HIV / AIDS	☐	☐
40. Tumor, abnormal growth	☐	☐
41. Radiation therapy	☐	☐
42. Chemotherapy	☐	☐
43. Emotional problems	☐	☐
44. Psychiatric treatment	☐	☐
45. Antidepressant medication	☐	☐
46. Alcohol / drug dependency	☐	☐
Are you?		
46. Presently being treated for any other illness	☐	☐
47. Aware of a change in your health in the last 24 hours (Fever, chills, new cough or diarrhea)	☐	☐
48. Taking medication for weight management (i.e. fen-phen)	☐	☐
49. Taking dietary supplements	☐	☐
50. Often exhausted or fatigued	☐	☐
51. Subject to frequent headaches	☐	☐
52. A smoker or smoked previously	☐	☐
53. Considered a touchy person	☐	☐
54. Often unhappy or depressed	☐	☐
55. FEMALE - taking birth control pills	☐	☐
56. FEMALE - pregnant	☐	☐
57. MALE – prostate disorders	☐	☐

Circle: I have taken / I currently take - Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), Skelid (tiludronate), Didronel (etidronate) IV - Aredia (pamidronate), Zometa (zolendronic acid), Bonefos (clodronate)

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Dental History

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient?_____ ☐ Months ☐ Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]. ☐ ☐
2. Have you had an unfavorable dental experience? ☐ ☐
3. Have you ever had complications from past dental treatment? ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ☐ ☐
6. Have you had any teeth removed? ☐ ☐

GUM AND BONE

7. Do your gums bleed when brushing or flossing? ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ☐ ☐
11. Have you ever experienced gum recession? ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ☐ ☐
13. Have you experienced a burning sensation in your mouth? ☐ ☐

BITE AND JAW JOINT

14. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping). ☐ ☐
15. Do you / would you have any problems chewing gum? ☐ ☐
16. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? ☐ ☐
17. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ☐ ☐
18. Are your teeth crowding or developing spaces? ☐ ☐
19. Do you have more than one bite and squeeze to make your teeth fit together? ☐ ☐
20. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐ ☐
21. Do you clench your teeth in the daytime or make them sore? ☐ ☐
22. Do you have any problems with sleep or wake up with an awareness of your teeth? ☐ ☐
23. Do you wear or have you ever worn a bite appliance? ☐ ☐

TOOTH STRUCTURE

24. Have you had any cavities within the past 3 years? ☐ ☐
25. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ☐ ☐
26. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ☐ ☐
27. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ☐ ☐
28. Do you have grooves or notches on your teeth near the gum line? ☐ ☐
29. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐ ☐
30. Do you get food caught between any teeth? ☐ ☐

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? ☐ ☐
32. Have you ever whitened (bleached) your teeth? ☐ ☐
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth? ☐ ☐
34. Have you been disappointed with the appearance of previous dental work? ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____