David A. Tecosky, DMD

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental History

Previous Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for not returning to previous dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had complications associated with dental treatment? Y/N If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times do you: brush/day? \_\_\_\_\_\_ floss/week? \_\_\_\_\_\_\_ Do your gums bleed? Y/N

Have you ever been told you have periodontal disease? Y/N Were you treated Y/N When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your teeth sensitive to: hot Y/N cold Y/N sweets Y/N other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you clench/grind your teeth: while sleeping? Y/N during the day? Y/N

Do your jaws: feel tired? Y/N click? Y/N lock? Y/N Have you been diagnosed with TMJ Disorder? Y/N

Do you have frequent or severe headaches? Y/N Are you missing any teeth? Y/N

Have you ever been told by a dentist you need to wear a night guard? Y/N If yes, do you wear one? Y/N

Have you ever had any injuries to your face/jaw? Y/N Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever have orthodontic treatment? Y/N Have you had your wisdom teeth extracted? Y/N

Do you wear full or partial removable dentures? Y/N If yes, how long have you had them? \_\_\_\_\_\_ Top/Bottom/Both

Are you satisfied with the appearance of your teeth/smile? Y/N If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in whitening your teeth? Y/N

Please add anything you feel is important for us to know. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History

Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for any of the following? (Please circle Y or N and clarify all Y answers by circling the condition.)

Y/N Abnormal Bleeding/Hemophilia/Bleeding Disorders Y/N STD/HIV/AIDS

Y/N Alcohol/Drug Abuse Y/N Liver Disease/Kidney Problems

Y/N Anemia Y/N Thyroid Disease/Jaundice/Hepatitis A/B/C

Y/N Arthritis/Osteoporosis Y/N Rheumatic Fever/Scarlet Fever

Y/N Artificial Joints/Heart Valves Y/N High/Low Blood Pressure

Y/N Asthma/Emphysema/Difficulty Breathing Y/N Neurological Disorders

Y/N Lung Disease/TB Y/N Psychiatric Problems

Y/N Allergies/Hay Fever/Sinus Disease Y/N Sickle Cell Disease/Trait

Y/N Epilepsy/Seizures/Fainting Spells Y/N Shingles/Lupus/Scleroderma

Y/N Glaucoma Y/N Cancer (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Heart Murmur/Mitral Valve Prolapse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Heart Attack or Surgery/Pacemaker/Stroke Y/N Allergies to Latex/Medications/Other: Specify

Y/N Diabetes: Type 1/Type 2 Hypo/Hyper Glycemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Tobacco Use: Current/Former Y/N Sleep Disorders: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cigars/Cigarettes/Smokeless Tobacco

Y/N Do you have any conditions not listed, we should know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women Only: Are you on birth control? Y/N Are you nursing? Y/N Are you pregnant? Y/N Due Date \_\_\_\_\_\_\_\_\_

Family History:

Y/N Heart Disease/Diabetes/Periodontal Disease If yes who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date