ORIGIN
DENTAL WELLNESS

Date ______-______-______

Please Print **general** information

PATIENT NAME Last ______________________________ First _______________________________ Nickname________________________

DATE OF BIRTH _____-______-______ ☐ MALE ☐ FEMALE ☐ Married ☐ Single ☐ Child

HOW DID YOU HEAR ABOUT OUR PRACTICE? ____

ADDRESS____ CITY _________________________ STATE _______ ZIP ________________

PHONE Home ____________________________ Work _______________________________ Cell _________________________________

EMAIL ___________________________________ How do you prefer to be contacted? ☐ Email ☐ Phone: ___home ___work ___ cell ___

EMPLOYER INFORMATION ____

SSN (for insurance purposes) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ LICENSE NUMBER ____

EMERGENCY CONTACT 1: NAME ___________________________Relationship to you __________________ Phone ________________

EMERGENCY CONTACT2: NAME ___________________________ Relationship to you __________________ Phone ________________

INSURED OR RESPONSIBLE PARTY INFORMATION:

NAME __________________________________ Is insured an existing patient? ☐ Yes ☐ No Relationship to Patient _____________

ADDRESS____

PHONE H) ____________________________ W) _____________________________ C) ______________________________

DATE OF BIRTH _____________________ SSN (insurance purposes) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

INSURED EMPLOYER NAME____ EMPLOYER PHONE ____________________________

EMPLOYER ADDRESS ____

INSURANCE PLAN NAME __________________________________ ID# ____________________________GROUP # __________________

ADDRESS ____ PHONE_______________________________

Please Print

medical information

DO YOU HAVE OR HAVE YOU EVER HAD:

☐ Allergic reaction to:

___ aspirin, ibuprofen or acetaminophen
___ penicillin
___ erythromycin
___ tetracycline
___ codeine
___ local anesthetic
___ fluoride
___ metals (gold, nickel)
___ latex
___ other ______________________________

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Blood Pressure: __ High __ Low
☐ Cancer: __________________
☐ __ Radiation __ Chemotherapy
☐ Cyst or abnormal growth
☐ Diabetes
☐ Depression
☐ Digestive Disorders
☐ Dizziness
☐ Epilepsy/Seizures

☐ Fainting
☐ Glaucoma
☐ Head Injury
☐ Heart Disease
☐ Hepatitis
☐ HIV/AIDS
☐ Hives or skin rash
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental or Nervous Disorders
☐ Osteoporosis, Osteopenia, Paget's Disease
Medications____________________________________
☐ Pacemaker
☐ Respiratory: ____ COPD ____ Emphysema

☐ Sinus Problems
☐ STD
☐ Stomach Problems/Acid Reflux
☐ Stroke
☐ Thyroid or Parathyroid Disease
☐ Tuberculosis

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
FEMALES: ARE YOU PREGNANT OR MIGHT YOU BE? ☐ YES Due Date ________________ ☐ NO
DO YOU USE TOBACCO? ☐ YES what type? _________________________ how much or how often _______________________ ☐ NO
LIST ANY MEDICATIONS, HERBAL SUPPLEMENTS, AND/OR VITAMINS YOU ARE TAKING: ____

____
____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING SURGERY, OR OTHER HEALTH ISSUES YOU CURRENTLY HAVE:
____
____
____
____

Please Print

dental history

REFERRED BY ....

HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PREVIOUS DENTIST .... HOW LONG WERE YOU A PATIENT? .... Months / Years

MOST RECENT: DENTAL EXAM ..../......./....... X-RAYS ..../......./....... TREATMENT (other than cleaning) ..../......./.......

HOW OFTEN DO YOU SEE YOUR DENTIST? Every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ....

PLEASE ANSWER YES OR NO TO EACH OF THE FOLLOWING QUESTIONS:

PERSONAL HISTORY

	YES	NO
1. Are you fearful of dental treatment? If yes, rate on a scale of 1-10 (ten being very fearful): _____ - - -	○	○
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 reactions to local anesthetic? - - - - - - - - - - - - - - - -	○	○
5. Did you ever have braces, orthodontic treatment or your bite adjusted? -	○	○
6. Have you had any teeth removed? -	○	○

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? - - - - - - - - - - - - ◯ ◯
8. Have you ever whitened (bleached) your teeth? - ◯ ◯
9. Are you self-conscious about your teeth? - ◯ ◯
10. Have you been disappointed with the appearance of previous dental work? - - - - - - - - - - - - - - - - - - ◯ ◯

BITE & JAW JOINT

11. Do you have any problems chewing gum? - ◯ ◯
12. Do you have any problems chewing bagels or other hard foods? - ◯ ◯
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? - - - - - - - - - - - - - - - - ◯ ◯
14. Are your teeth crowding or developing spaces? - ◯ ◯
15. Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together? - - - - - ◯ ◯
16. Do you have any problems with sleep in general, or wake up with an awareness of your teeth? - - - - - ◯ ◯
17. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? - - - - - ◯ ◯
18. Do you have tension headaches or sore teeth? - ◯ ◯
19. Do you wear, or have you ever worn a bite appliances? - ◯ ◯

TOOTH STRUCTURE

YES NO

20. Have you had any cavities in the past 3 years? - ◯ ◯
21. Do you have a dry mouth? - ◯ ◯
22. Are any teeth sensitive to hot, cold, biting or sweets? - ◯ ◯
23. Have you ever had a toothache, cracked filling, or a broken, chipped or cracked tooth? - - - - - - - - ◯ ◯
24. Do you avoid brushing any part of your mouth? - ◯ ◯
25. Do you feel or notice any holes (pitting) in your teeth? - ◯ ◯

GUM & BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? - ◯ ◯
27. Have you ever experienced gum recession? - ◯ ◯
28. Is there anyone with a history of periodontal disease in your family? - ◯ ◯
29. Do your gums bleed when brushing, flossing or eating? - ◯ ◯
30. Are your teeth becoming loose? - ◯ ◯
31. Have you ever noticed an unpleasant taste or odor in your mouth? - ◯ ◯
32. Have you experienced a burning sensation in your mouth? - ◯ ◯

I consent to dental and oral surgical procedures deemed necessary or advisable, including the use of local anesthetic; I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing Dr. Toler of any changes to my health at my next appointment.

PATIENT SIGNATURE ______________________________ DATE _________ DOCTOR SIGNATURE ___________________________ DATE __________

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