David M. Kimler Dentistry, PLLC

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PATIENT INFORMATION

Patient Name:	Nickname:	Date of Birth:	Age:

Patient Address:	City:	State:	Zipcode:

Sex: *(M/F)*	Social Sec No:	Home Phone:	Mobile Phone:	Email Address:

Pt. Representative Name: *(Responsible Party to Confirm Appts)*	Company (if applicable):

Address:	Primary Contact Phone:	Work Phone:

City:	State:	Zip:	Email Address/Website:

Name of Independent Support Coordinator (ISC) & Agency:

Additional Patient Notes/Comments:

DENTAL INFORMATION & HISTORY

Why are you here today?

Are you having Pain/Discomfort? ☐ YES ☐ NO	*If **YES***, Where?

How would you rate your condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	I routinely see a dentist every: ☐ 3 mo ☐ 6 mo ☐ 1 yr ☐ Not Often

Have you been to a Dentist in the Past 2 Years? ☐ YES ☐ NO	*If **YES***, List Dentist's Name/Practice Name:	
	Address:	Phone Number:

PERSONAL HISTORY	YES	NO		YES	NO
1. Are fearful of dental treatment?	☐	☐	4. Ever had trouble getting numb/reactions to anesthetic?	☐	☐
2. Have you had unfavorable dentist experience?	☐	☐	5. Ever had complications to past dental treatments?	☐	☐
3. Have you ever had any teeth removed?	☐	☐	6. Ever have braces, orthodontic treatment, etc?	☐	☐

GUM & BONE	YES	NO		YES	NO
7. Do gums bleed/painful when brushing or flossing?	☐	☐	10. Family history of periodontal disease in your family?	☐	☐
8. Ever treated for gum disease or lost bone around teeth?	☐	☐	11. Ever experienced gum recession?	☐	☐
9. Noticed unpleasant taste/odor in your mouth?	☐	☐	12. Have experienced a burning sensation in mouth?	☐	☐

DENTAL HISTORY CONTINUED

TOOTH STRUCTURE	YES	NO		YES	NO
13. Have you had any Cavities within past 3 years?	☐	☐	17. Teeth sensitive hot/cold or biting sweets?	☐	☐
14. Too little saliva in your mouth/difficulty swallowing?	☐	☐	18. Ever broken/chipped a tooth?	☐	☐
15. Notice any holes on biting surface of your teeth?	☐	☐	19. Have you ever broken/cracked a filling?	☐	☐
16. Are there grooves/notches near the gum line?	☐	☐	20. Does food frequently get caught between teeth?	☐	☐

BITE AND JAW JOINT	YES	NO		YES	NO
21. Do you have problems/sounds with your jaw joint?	☐	☐	26. Have more than 1 bite/squeeze to make teeth fit?	☐	☐
22. Feel like lower jaw being pushed back when biting?	☐	☐	27. Chew ice, bite nails, hold objects, or other habits?	☐	☐
23. Difficulty chewing gum or other hard/dry foods?	☐	☐	28. Do you clench teeth in daytime to make sore?	☐	☐
24. Have teeth changed in last 5 yrs. (shorter/thinner)?	☐	☐	29. Have problems sleeping/wake up b/c of teeth?	☐	☐
25. Are your teeth crowding or developing spaces?	☐	☐	30. Do you/have you ever worn bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO		YES	NO
31. Would you like to change anything about your smile?	☐	☐	33. Do you feel uncomfortable/self-conscious w/ smile?	☐	☐
32. Have you ever bleached/whitened your teeth?	☐	☐	34. Ever been disappointed with past dental work?	☐	☐

Any Other Dental **Notes/Comments**:

MEDICAL HISTORY

Have you been to a Medical Doctor Past 2 Years?

☐ **YES**
☐ **NO**

If **YES**, Medical Doctor's Name: *(if Available)*

Doctor's Address

Phone Number

Allergic to any Medication? ☐ **YES** ☐ **NO**

*If **YES***, Please List Allergies:

Taken Medication Past 2 Years? ☐ **YES** ☐ **NO**

Do you current take any **Medication**?

☐ **YES**
☐ **NO**

If **YES**, List Medications Below:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Ask for additional sheet if you require more space for medication.

DO YOU HAVE / EVER HAD…	YES	NO		YES	NO
1. Have you ever been hospitalized for illness/injury?	☐	☐	14. Asthma?	☐	☐
2. Had heart problems within the past 6 months?	☐	☐	15. Breathing or sleep problems (apnea, sinus issues)?	☐	☐
3. History of endocarditis?	☐	☐	16. Kidney disease?	☐	☐
4. Artificial heart valve, repaid heart defect?	☐	☐	17. Liver disease?	☐	☐
5. Do you have a pacemaker/implantable defibrillator?	☐	☐	18. Stomach ulcers / digestive issues (gastric reflux)?	☐	☐
6. Artificial prosthesis?	☐	☐	19. High cholesterol or taking statin drugs?	☐	☐
7. Rheumatic or scarlet fever?	☐	☐	20. Jaundice?	☐	☐
8. Do you/have you ever had high blood pressure?	☐	☐	21. Diabetes (HbA1c = _____)	☐	☐
9. Have you ever had a stroke?	☐	☐	22. Osteoporosis/osteopenia?	☐	☐
10. Anemia or other blood disorder?	☐	☐	23. Arthritis, rheumatoid arthritis, lupus?	☐	☐
11. Prolonged bleeding due to slight cut?	☐	☐	24. Glaucoma?	☐	☐
12. Emphysema, shortness of breath, sarcoidosis?	☐	☐	25. Contact Lenses?	☐	☐
13. Tuberculosis, measles, chicken pox?	☐	☐	26. Head and/or neck injuries?	☐	☐