BEVERIDGE
DENTAL

Date: ______________________

Patient #: ______________________

Patient Information (confidential)

Name: ______________________ Birthdate: ______________________

Physician: ______________________ Office phone: ______________________ Date of last exam: ______________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you ever taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you smoke?	☐	☐
8. Do you chew tobacco?	☐	☐
9. Do you use e-cigarettes or vapor pens?	☐	☐
10. Do you use controlled substances?	☐	☐
11. Are you wearing contact lenses?	☐	☐
12. Are you allergic to or have you had any reactions to:		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex rubber	☐	☐
Other (please list) ______________________		
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
14. Women only:		
a) Are you pregnant or do you think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Information (confidential)

Do you have or have you had any of the following? (check all that apply)

- ☐ AIDS or HIV infection
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disease
- ☐ Cancer
- ☐ Cardiac pacemaker
- ☐ Chest pains
- ☐ Diabetes
- ☐ Dizziness
- ☐ Easily winded
- ☐ Emphysema
- ☐ Epilepsy / convulsions
- ☐ Excessive bleeding
- ☐ Fainting / seizures
- ☐ Frequently tired
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay fever / allergies
- ☐ Head injuries
- ☐ Hepatitis / jaundice
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Joint replacement or implant
- ☐ Kidney disease
- ☐ Leukemia
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mental disorders
- ☐ Mitral valve prolapse
- ☐ Radiation therapy
- ☐ Recent weight loss
- ☐ Respiratory problems
- ☐ Rheumatic Fever
- ☐ Sexually transmitted disease
- ☐ Sinus problems
- ☐ Stomach trouble / ulcers
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid problem
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Other ______________________

Continued on reverse

Dental History (confidential)

Patients frequently consult us as a second opinion. Have you seen another dentist for your needs? ☐ Yes ☐ No If yes, please explain:

Previous dentist's name: Office phone: Date of last exam:

Have you ever experienced complications following dental treatment? ☐ Yes ☐ No If yes, please explain:

Please rate the condition of your teeth and gums: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please rank the following in order of what would prevent you from seeking dental treatment: ☐ Fear of pain ☐ Cost of treatment ☐ Missing work time ☐ No concern

How often do you brush your teeth? Floss your teeth?

If you could change the appearance of your smile, what would you like to do?

What would you most like to change about the appearance of your teeth?

Is there anything in particular that you would like us to look at today?

Dental Evaluation

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Do you feel pain in any of your teeth or gums?	☐	☐
3. Are your teeth sensitive to hot or cold liquids or foods?	☐	☐
4. Are your teeth sensitive to sweet or sour liquids or foods?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty in chewing	☐	☐
7. Have you been treated for TMJ symptoms? If yes, please explain:		

	Yes	No
8. Do you clench or grind your teeth?	☐	☐
9. Do you have any sores or lumps in or near your mouth?	☐	☐
10. Do you have frequent headaches?	☐	☐
11. Have you ever had any prolonged bleeding after an extraction?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials? If yes, date of placement:	☐	☐
14. Have you ever received oral hygiene instructions regarding the care of your teeth / gums?	☐	☐
15. Would you be interested in an easy and safe way to whiten your teeth	☐	☐
16. Have you been treated for periodontal/gum disease? If yes, when?	☐	☐

Smile Evaluation

	Yes	No
1. Do you like the appearance of your teeth?	☐	☐
2. Do you like the color of your teeth?	☐	☐
3. Are your teeth in alignment?	☐	☐
4. Do you like the shape of your teeth?	☐	☐

	Yes	No
5. Are there spaces between your teeth that you don't like?	☐	☐
6. Are your teeth chipped or cracked?	☐	☐
7. Do you have unsightly fillings or dental work?	☐	☐
8. Do you like the way your teeth come together?	☐	☐

Authorization and Release

I certify that I have provided correct information and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that the above information will be held in the strictest confidence and will only be used to improve communication between the doctor and myself. I authorize the doctor to contact the medical and dental professionals named above to obtain further information if necessary. I also authorize the doctor to use any photographs or video footage they may take for lecturing or educational purposes.

Signature of patient (or parent / guardian if minor) Date