

Dental Questionnaire

Last _____ First _____ MI _____ "Common Name" _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? Yes No
2. Have you ever had any serious trouble associated with previous dentistry? Yes No
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Date of last dental visit? _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
6. How often do you brush? _____ Floss? _____ My tooth-brush is: Soft Medium Hard
7. Do you have or have you ever had any of the following:

MOUTH

- Bleeding, Sore Gums Yes No
Unpleasant taste/bad breath Yes No
Burning tongue/lips Yes No
Frequent blisters, lips/mouth Yes No
Swelling/lumps in mouth Yes No
Ortho treatment (braces) Yes No
Biting cheeks/lips Yes No
Clicking/Popping jaw Yes No
Difficulty opening or closing jaw Yes No

Do you use the following?

- Brush Yes No
Fluoride Rinse Yes No

TEETH

- Loose Teeth Yes No
Sensitive to HOT Yes No
Sensitive to COLD Yes No
Sensitive to Sweets Yes No
Sensitive to Biting Yes No
Food impaction Yes No
Clenching/Grinding Yes No

- Dental Floss Yes No
Other _____

What do you feel is your major problem? (cavities, gum disease, toothache, worn teeth, crooked teeth, headaches, pain, jaw function, chewing, etc.) _____

- Yes No Do you clench your teeth while you are sleeping?
 Yes No Has anyone told you they have heard you grind your teeth while you are sleeping?
 Yes No Must you chew on one side exclusively?
 Yes No Do you have any symptoms upon waking in the morning such as:
 Yes No Stiff Jaw? Yes No Sore Jaw? Yes No Headache?
 Yes No Sore Teeth? Yes No Cracking or locking of either jaw joint (TMJ)?
 Yes No Have you ever been treated for TMJ, TMD, jaw joint pain or discomfort? Who: _____

Signature of Patient or Guardian

Date

Medical Questionnaire

Correct answers to the following questions will allow your dentist to treat you so there **WILL NOT** be an emergency. However, if an emergency situation does arise this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

Do you have or have you ever had:

NOTES:

Anemia Yes No

Diabetes Yes No

Allergies

To penicillin Yes No

To Latex Yes No

To local anesthetic Yes No

Other _____ Yes No

Cancer--benign/malignant Yes No

Abnormal heart condition or heart murmur Yes No

Abnormal bleeding from a cut Yes No

Rheumatic fever Yes No

Respiratory Disease or Asthma Yes No

Hepatitis Yes No

HIV/AIDS Yes No

Pregnant/breast feeding Yes No If pregnant, due date _____

Are you under the care of a physician now? Yes No

Are you taking any medication for pain or depression? Yes No

If yes, What? _____

Are you taking any other medications for any other reason? Yes No

If yes, What? _____

*Please comment on any medical or dental history that you feel may be important in the diagnosis and treatment of your condition. Please use the reverse side of this form if you need additional space.

Date of last medical examination? _____

Blood pressure _____

Name of Physician _____

Other Physical Conditions _____

Name of nearest relative _____

**Emergency Contact Phone Number _____

Signature of Patient or Guardian

Date



Informed Consent & General Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but not limited to:

- Drug reactions: nausea, vomiting, drowsiness, and unexpected or allergic reactions.
- Cardiovascular or respiratory responses, which may lead to heart attack, stroke or death.
- Involvement of the nerves during oral surgery or administration of local anesthesia resulting in temporary or possible permanent numbness or tingling of the lip, chin, tongue, or other areas of the face or neck.
- Sinus involvement during the removal of upper molars, which may require additional treatment or surgical repair at a later date or by an oral surgeon.
- Incomplete removal of tooth fragments to avoid injury to vital structures such as nerves or sinus, occasionally small root tips may be left in place.
- Jaw fracture – while quite rare, it is possible in difficult or deeply impacted teeth.
- Breakage of dental instruments inside tooth canals requiring additional treatment.
- Damage to adjacent teeth or fillings.
- Post-operative complications may include: delayed healing of an extraction site, dry socket, infection, continued bleeding, bruising, swelling, sensitivity, or pain.

***While unfortunate, some dental procedures do fail and complications are possible.*

Any of the above conditions may indicate further treatment and/or a referral to a specialist if needed.

****In addition, it may be necessary to:**

Contact patients via telephone and/or mail at home or at work. Use and/or disclose health/dental/information to healthcare providers, insurance companies, and/or, any other business associates regarding treatment, payment, or other healthcare operations.

All conditions apply unless requested by patient.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____



Appointment and Cancellation Policy

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge for not showing up for scheduled appointments. *Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I may refuse to sign this acknowledgement.

I have received or asked for a copy of *Sooner Dental Care's* notice of Privacy Practices.

Please Print Name

Patient/Guardian Signature

Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: _____

Witness Signature Date



3150 E. 41st St., Suite 100
Tulsa, OK 74105
(918) 742-1480

Date: _____

Patient/Guardian Signature: _____

Patient Name: _____

I consent for Sooner Dental Care to share my personal information with the following: (family, friends, etc)

Name/Relationship:

1. _____ / _____
2. _____ / _____
3. _____ / _____
4. _____ / _____