BLUE SPRUCE DENTAL

Kevin R. Timm, DDS

Medical and Dental Information

Dentistry has changed significantly in the last few years and these new technologies require more information to treat you safely and completely. The following is important information about your physical and dental health as well as some questions about lifestyle. Your honest and complete answers allow us to serve you to the best of our ability.

Name____________________________Date of Birth____________Social Security #______________

Address ____Home # ____________________

City, State, Zip____Work # ____________________

Drivers License # __________________Cell # _________________Email: ______________________

Emergency Contact (not living with you) ______________________Phone # ____________________

Spouse ___________________________Children ____

Whom may we thank for referring you to our office: _______________________________________

General Health Information

Physicians Name_________________________City___________________Phone_________________

Last Physical Exam______________________Rate Health Good / Fair / Poor

Are you taking any medications or drugs (including Aspirin) YES / NO

Name of Medicine	Dosage	Times per day	Purpose

Allergies to: ____

Have you ever been Premedicated for dental treatment? YES / NO Reason ____________________

Have you ever had a Hip, Knee, or other Joint replaced? YES / NO If yes, when ________________

Do you have any of the following? Check all that apply….

	Cancer		Drug Addiction		Rheumatic Fever		Asthma
	Hormone Therapy		Radiation/Chemotherapy		Diabetes		Epilepsy
	Heart Murmur		Blood Transfusion		Thyroid Problem		Tuberculosis
	Heart Surgery		High Blood Pressure		Hepatitis		Headaches
	Heart Disease		Neurological Disorder		AIDS/HIV		

Any disease, condition or problem not listed:____

WOMEN: Are you Pregnant or Planning Pregnancy? YES / NO Oral Contraception? YES / NO

(OVER)

DENTAL INFORMATION

Name of Previous Dentist________________________City______________Phone#________________

Date of Last Exam__________________Purpose____

What did you like **best** about your previous Dentist?____

What did you like **least** about your previous Dentist?____

Are you aware of any dental problems? YES / NO Explain_________________________________

Date of last Bitewing Xrays:________________Date of last Full series or Panorex?________________

Have you ever had Braces? YES / NO Orthodontist Name__________________________________

Have you ever used Nitrous Oxide? YES / NO How did you like it?__________________________

Do you have a Bite Guard or Bite Splint? YES / NO If so, how long? __________________________

Have you ever been treated for Periodontal Disease? YES / NO If yes, when? __________________

Have you ever had an injury to your Head or Neck? YES / NO If yes, What and When? ___________

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Do you drink Pop? YES / NO Coffee? YES / NO Amount per day_____________________

Do you or have you ever used tobacco products? YES / NO Type?____________ Amount?_________

How many years have you used tobacco? _______________ If you quit, when? __________________

Would you be interested in whitening their teeth? YES / NO

Does your bite feel even and balanced on both sides? YES / NO

Do you ever have a popping or clicking in your jaw? YES / NO

What would you consider your pain threshold to be: LOW AVERAGE HIGH

How nervous or worked up do you get during dental appointments? ____________________________

Please rate the health of your mouth 1-10 (10 being best)_________What do you want it to be?______

What would you like to change about your smile?

Do you have any other comments or concerns we should know about?

I understand that in order to receive the best care, I must do my part to help the doctor and answer these questions to the best of my ability. I certify that the above information is complete and accurate. If I have dental insurance, I realize that the full bill is my responsibility and authorize Dr. Timm to work as my agent to assist me in receiving payment from my insurance company.

Patient Signature____Date__________________