Aesthetic Dentistry of Bernardsville

Patti Swaintek-Lamb, D.M.D

Patient Name: _____Date:_____

Address:_____

Home Phone:( )_____Work Phone:_____

Physician's Name: _____ Phone: ( )_____

Occupation:_____ Employer:_____

Date of Birth:____/____/____ Sex: M F SS#_____

We can send you confirmations and reminders by email or text messaging. If you are interested please fill in the information below. We encourage this.

Email:_____ Cell Phone:_____

Emergency Contact:_____Relationship:_____Phone:_____

If you are completing this form for another person, what is your relationship to that person?

Name:_____Relationship:_____

Insurance: _____

Policy Holder's Name_____ _____ DOB:_____Social Security #:_____

Name of Carrier:_____ Group #_____

For the following questions, please circle whichever applies to you, "Y" for yes it applies; "N" for no it does not apply; "U" for unsure or don't know if it applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health or family history. **This information is vital to allow us to provide appropriate care for you.** This office does not use this information to discriminate.

Dental Information

Date of your last dental exam:_____ Date of last dental x-rays:_____

Are you having any discomfort at this time? _____ If yes, please explain: _____

_____

Y	N	U	Have you ever been treated for gum disease?
Y	N	U	Have you had gum surgery?
Y	N	U	Do you use fluoride rinse routinely?
Y	N	U	Do you use dental floss routinely?
Y	N	U	Have you lost any permanent teeth?
Y	N	U	Have they been replaced? If not, why_____
Y	N	U	Are you unhappy with the replacement? If yes, why_____
Y	N	U	Would you like to know about permanent replacement?
Y	N	U	Have you ever had Novocain?
Y	N	U	Do you have trouble getting numb?
Y	N	U	Have you had any problems or complications with previous dental treatment?

Do you have or have you ever had any of the following:

Y	N	U	Bleeding/sore gums	Y	N	U	Loose teeth
Y	N	U	Unpleasant taste/bad breath	Y	N	U	Sensitivity to hot
Y	N	U	Burning tongue/lips	Y	N	U	Sensitivity to cold
Y	N	U	Frequent blisters lip/mouth	Y	N	U	Sensitivity to sweets

Y	N	U	Swelling/lumps in mouth	Y	N	U	Sensitivity to biting
Y	N	U	Orthodontics (braces)	Y	N	U	Catching food in teeth
Y	N	U	Biting cheeks/lips	Y	N	U	Clenching/grinding
Y	N	U	Difficulty opening/closing	Y	N	U	Shifting in bite
Y	N	U	Clicking/popping jaw	If so, when:_____			

Please circle A, B, or C:

My mouth is_____

A) very comfortable
B) moderately comfortable
C) uncomfortable

I have _____

A) set goals for my dental health
B) never set goals but would like to
C) never set goals, nor will I

I put dentistry_____

A) high on my priority list
B) low on my priority list
C) on my list hard to find

I _____

A) will do anything to keep my teeth
B) want to keep my teeth but have limited budget
C) believe loosing teeth is part of aging

My present state of dental health is_____

A) Excellent
B) Good
C) Poor

I am_____

A) very satisfied with the appearance of my mouth
B) somewhat satisfied with the appearance of my mouth
C) dissatisfied with the appearance of my mouth

Does dental treatment make you nervous? No Slightly Moderately Very

Is there anything else you would like us to know about your dental health, past dental experiences, or any questions you have about dental health?_____

_____

Please check off the symptom(s) if they apply to you:

- Frequent heavy snoring
- Frequent heavy snoring which affects the sleep of others
- Significant daytime drowsiness
- I have been told that "I stop breathing when sleeping"
- Difficulty falling asleep
- Gasping when waking up
- Nighttime choking spells
- Feeling unrefreshed in the morning
- Morning hoarseness
- Morning headaches
- Swelling in ankles or feet
- Nocturnal teeth grinding
- Jaw pain
- Facial pain
- Jaw clicking

Health History

Medical Information

Please circle any condition that applies to you. If you don't know, please underline it.

Aspirin allergy	Penicillin allergy	Sulfa drug allergy
Birth control	Pregnant	Pre-term birth
High blood pressure	Low blood pressure	Heart problems_____
Chemotherapy	Cancer_____	Radiation treatment
Heart valve replacement	Blood disorder	Bleeding problem
Stomach problems	Ulcer	Diabetes
Breathing problem	Asthma	Glaucoma
Fainting	STD_____	AIDS
HIV positive	Hepatitis	Kidney disease
Stroke	Thyroid disease	Artificial joint_____
Anxiety	Depression	Arthritis
Smoke/chew tobacco	Eating disorder	Substance abuse

Have you ever been hospitalized or had any operations within the last 12 months? If yes, please explain.

_____

_____

Please list Medications/vitamins you are currently taking:_____

_____

Are you currently under a physician's care? If yes, please explain._____

_____

Is there anything else you would like us to know about your medical history condition?_____

_____

Any other allergies not listed above:_____

_____

Health History

Family Medical History

Please circle any condition that applies to your parents.

Heart disease	Stroke	High blood pressure
Low blood pressure	Diabetes	Cancer _____
Heart attack	Pre-term birth	Gum disease
Tooth Loss	Dentures	

Note: Both the doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

Please list whom we may thank for referring you_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/staff, responsible for any action they take or do not take because of errors or omissions that I made in the completion of this form.

- PLEASE NOTE: THERE WILL BE A FEE FOR CANCELLATIONS PROVIDING LESS THAN 24 HOURS NOTICE. THERE WILL ALSO BE A FEE FOR MISSED APPOINTMENTS. PLEASE INITIAL x_____
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_____ _____

Signature of Patient or Legal Guardian Date