



PATIENT INFORMATION

Welcome to our practice!
This confidential information will help us prepare for your visit.

NAME <input type="radio"/> MRS <input type="radio"/> MR <input type="radio"/> MS <input type="radio"/> REV <input type="radio"/> DR				I PREFER TO BE ADDRESSED AS			
BIRTHDATE				SS #			
ADDRESS				EMAIL			
I AM <input type="radio"/> SINGLE <input type="radio"/> MARRIED <input type="radio"/> DIVORCED <input type="radio"/> WIDOWED <input type="radio"/> SEPARATED				WHOM MAY WE THANK FOR REFERRING YOU?			
HOME PHONE #		CELL PHONE #		WORK PHONE #			
EMPLOYER ADDRESS		EMPLOYER NAME		OCCUPATION			
<p>We may use an automated appointment reminder system that can send you convenient email, text messages, and/or postcards. We may also call and if necessary leave brief voicemail messages.</p> <p>If you would prefer NOT to receive routine reminders from us via certain methods, please indicate below:</p> <p><input type="checkbox"/> NO TEXT MESSAGES <input type="checkbox"/> NO EMAILS <input type="checkbox"/> NO CELL PHONE <input type="checkbox"/> NO HOME PHONE <input type="checkbox"/> NO WORK PHONE <input type="checkbox"/> NO POSTCARDS</p>							
FAMILY MEMBERS SEEN AS PATIENTS HERE							
SPOUSE'S NAME				SPOUSE'S BIRTHDATE			
SPOUSE'S SS#		SPOUSE'S CELL PHONE #		SPOUSE'S WORK PHONE #			
SPOUSE'S EMPLOYER ADDRESS		SPOUSE'S EMPLOYER NAME		SPOUSE'S OCCUPATION			
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE #		EMERGENCY CONTACT RELATIONSHIP			
PERSON FINANCIALLY RESPONSIBLE <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> OTHER	RESPONSIBLE PARTY NAME (IF OTHER)		RESPONSIBLE PARTY PHONE # (IF OTHER)		RESPONSIBLE PARTY SS # (IF OTHER)		
RESPONSIBLE PARTY ADDRESS (IF OTHER)				RESPONSIBLE PARTY RELATIONSHIP (IF OTHER)			
DENTAL INSURANCE COMPANY NAME		DENTAL INSURANCE COMPANY ADDRESS		DENTAL INSURANCE COMPANY PHONE #		GROUP #	
<p>CONCERNS I SEE ABOUT ACHIEVING OR MAINTAINING EXCELLENT DENTAL HEALTH ARE:</p> <p><input type="checkbox"/> I SEE NO OBSTACLES <input type="checkbox"/> TIME AWAY FROM WORK OR OTHER OBLIGATIONS <input type="checkbox"/> FEAR BECAUSE OF PAST DENTAL EXPERIENCES</p> <p><input type="checkbox"/> COST OF TREATMENT <input type="checkbox"/> FEAR OF POSSIBLE DISCOMFORT, PAIN, OR INJECTIONS</p> <p><input type="checkbox"/> OTHER (PLEASE EXPLAIN)</p>							
I BELIEVE MY PRESENT STATE OF DENTAL HEALTH IS <input type="radio"/> POOR <input type="radio"/> FAIR <input type="radio"/> GOOD <input type="radio"/> EXCELLENT				I AM AWARE OF THE CURRENT DENTAL TREATMENT THAT I NEED <input type="radio"/> YES <input type="radio"/> NO			
PLEASE SELECT ONE <input type="radio"/> I AM SATISFIED WITH MY SMILE <input type="radio"/> I AM CURIOUS HOW TO IMPROVE MY SMILE <input type="radio"/> I AM NOT SATISFIED WITH MY SMILE							



HEALTH HISTORY

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MY CURRENT MEDICAL HEALTH IS <input type="radio"/> EXCELLENT <input type="radio"/> GOOD <input type="radio"/> FAIR <input type="radio"/> POOR	I AM UNDER THE CARE OF A PHYSICIAN <input type="radio"/> YES <input type="radio"/> NO																																								
PHYSICIAN NAME	PHYSICIAN PHONE #																																								
PHYSICIAN ADDRESS																																									
PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDE BOTH PRESCRIPTION & OVER THE COUNTER)																																									
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> ANEMIA</td> <td><input type="checkbox"/> COLD SORES</td> <td><input type="checkbox"/> FEVER BLISTERS</td> <td><input type="checkbox"/> HIV/AIDS</td> <td><input type="checkbox"/> SCARLET FEVER</td> </tr> <tr> <td><input type="checkbox"/> ARTHRITIS</td> <td><input type="checkbox"/> COLITIS</td> <td><input type="checkbox"/> GLAUCOMA</td> <td><input type="checkbox"/> HOSPITALIZED</td> <td><input type="checkbox"/> SEVERE OR FREQUENT HEADACHES</td> </tr> <tr> <td><input type="checkbox"/> ARTIFICIAL JOINT</td> <td><input type="checkbox"/> DIABETES</td> <td><input type="checkbox"/> HEART ATTACK</td> <td><input type="checkbox"/> KIDNEY PROBLEMS</td> <td><input type="checkbox"/> SHINGLES</td> </tr> <tr> <td><input type="checkbox"/> ARTIFICIAL VALVE</td> <td><input type="checkbox"/> DIFFICULTY BREATHING</td> <td><input type="checkbox"/> HEART MURMUR</td> <td><input type="checkbox"/> MITRAL VALVE PROLAPSE</td> <td><input type="checkbox"/> SINUS PROBLEMS</td> </tr> <tr> <td><input type="checkbox"/> ASTHMA</td> <td><input type="checkbox"/> DRUG/ALCOHOL DEPENDENCE</td> <td><input type="checkbox"/> HEART SURGERY</td> <td><input type="checkbox"/> PACEMAKER</td> <td><input type="checkbox"/> STROKE</td> </tr> <tr> <td><input type="checkbox"/> BLOOD TRANSFUSION</td> <td><input type="checkbox"/> EMPHYSEMA</td> <td><input type="checkbox"/> HEMOPHILIA/BLEEDING</td> <td><input type="checkbox"/> PSYCHIATRIC PROBLEMS</td> <td><input type="checkbox"/> TUBERCULOSIS</td> </tr> <tr> <td><input type="checkbox"/> CANCER</td> <td><input type="checkbox"/> EPILEPSY/SEIZURES</td> <td><input type="checkbox"/> HEPATITIS</td> <td><input type="checkbox"/> RADIATION TREATMENT</td> <td><input type="checkbox"/> ULCERS</td> </tr> <tr> <td><input type="checkbox"/> CHEMOTHERAPY</td> <td><input type="checkbox"/> FAINTING</td> <td><input type="checkbox"/> HIGH/LOW BLOOD PRESSURE</td> <td><input type="checkbox"/> RHEUMATIC FEVER</td> <td><input type="checkbox"/> VENEREAL DISEASE</td> </tr> </table>		<input type="checkbox"/> ANEMIA	<input type="checkbox"/> COLD SORES	<input type="checkbox"/> FEVER BLISTERS	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> SCARLET FEVER	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> COLITIS	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> HOSPITALIZED	<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> ARTIFICIAL JOINT	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> ARTIFICIAL VALVE	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> MITRAL VALVE PROLAPSE	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DRUG/ALCOHOL DEPENDENCE	<input type="checkbox"/> HEART SURGERY	<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> STROKE	<input type="checkbox"/> BLOOD TRANSFUSION	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> HEMOPHILIA/BLEEDING	<input type="checkbox"/> PSYCHIATRIC PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> CANCER	<input type="checkbox"/> EPILEPSY/SEIZURES	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RADIATION TREATMENT	<input type="checkbox"/> ULCERS	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> FAINTING	<input type="checkbox"/> HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> VENEREAL DISEASE
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PLEASE CHECK ANY OF THE FOLLOWING DRUGS YOU HAVE USED AT ANY TIME <input type="checkbox"/> ACTONEL <input type="checkbox"/> AREDIA <input type="checkbox"/> BIOPHOSPHONATES/BISPHOSPHONATES <input type="checkbox"/> BONIVA <input type="checkbox"/> DIDRONEL <input type="checkbox"/> FOSAMAX <input type="checkbox"/> SKELID <input type="checkbox"/> ZOMETA																																									
ARE YOU ALLERGIC TO OR HAVE HAD DIFFICULTY WITH ANY OF THE FOLLOWING SUBSTANCES <input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> DENTAL ANESTHETIC <input type="checkbox"/> ERYTHROMYCIN <input type="checkbox"/> LATEX <input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFA <input type="checkbox"/> TETRACYCLINE <input type="checkbox"/> OTHER (PLEASE LIST): _____																																									
WOMEN ONLY ARE YOU PREGNANT? <input type="radio"/> YES <input type="radio"/> NO ARE YOU NURSING? <input type="radio"/> YES <input type="radio"/> NO ARE YOU TAKING BIRTH CONTROL? <input type="radio"/> YES <input type="radio"/> NO																																									
PLEASE SELECT ONE <input type="radio"/> I CURRENTLY HAVE NO DENTAL PAIN, JAW PAIN, OR SENSITIVITY <input type="radio"/> I CURRENTLY HAVE SOME DENTAL PAIN, JAW PAIN, OR SENSITIVITY																																									
PLEASE SELECT ONE <input type="radio"/> MY MOUTH IS VERY COMFORTABLE <input type="radio"/> MY MOUTH IS MODERATELY COMFORTABLE <input type="radio"/> MY MOUTH IS UNCOMFORTABLE																																									
<p>The information provided is accurate & complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.</p> <p>I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.</p>																																									
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE																																								



CAVITY RISK ASSESSMENT

Welcome to our practice!
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PATIENT NAME	DATE
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We are committed to helping you prevent cavities. The process of prevention begins with understanding the factors that cause cavities that are present for you. Some of these factors you will have control over and we are happy to discuss ideas to manage them. Other factors are beyond your control, but can be managed by the addition of things like special toothpastes, rinses and mints.

1. Do you get Fluoride in your water, toothpaste or at the dentist?.....	<input type="radio"/> YES	<input type="radio"/> NO
2. Do you eat sugary foods or drinks between meals?.....	<input type="radio"/> YES	<input type="radio"/> NO
3. Do you see a dentist regularly?.....	<input type="radio"/> YES	<input type="radio"/> NO
4. Have you had Chemotherapy or Radiation?.....	<input type="radio"/> YES	<input type="radio"/> NO
5. Have you had a cavity in the last 3 years?.....	<input type="radio"/> YES	<input type="radio"/> NO
6. Have you ever lost a tooth due to a cavity?	<input type="radio"/> YES	<input type="radio"/> NO
7. Do you currently have braces?	<input type="radio"/> YES	<input type="radio"/> NO
8. Do you have a dry mouth?.....	<input type="radio"/> YES	<input type="radio"/> NO
9. Have you or a close family member had a cavity in the last 2 years?.....	<input type="radio"/> YES	<input type="radio"/> NO
10. Have you or a close family member had a cavity in the last year?.....	<input type="radio"/> YES	<input type="radio"/> NO

STOP HERE!
(Below Portion To Be Completed With Your Dental Hygienist or Dentist)

1. Unusual Tooth Shapes.....	<input type="radio"/> YES	<input type="radio"/> NO
2. Visible Plaque.....	<input type="radio"/> YES	<input type="radio"/> NO
3. Fillings Between Teeth.....	<input type="radio"/> YES	<input type="radio"/> NO
4. Poor Fitting Fillings or Crowns.....	<input type="radio"/> YES	<input type="radio"/> NO
5. Exposed Tooth Roots.....	<input type="radio"/> YES	<input type="radio"/> NO
6. Medications Causing Dry Mouth	<input type="radio"/> YES	<input type="radio"/> NO
7. Other Factors	<input type="radio"/> YES	<input type="radio"/> NO

TOTAL CARIES RISK	<input type="radio"/> LOW	<input type="radio"/> MODERATE	<input type="radio"/> HIGH
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PERIO RISK ASSESSMENT

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PATIENT NAME _____	DATE _____																								
<p style="text-align: center;">TOBACCO USE</p> <p>Tobacco use is the most significant risk factor for gum disease.</p>	<p style="text-align: center;">DO YOU NOW OR HAVE YOU EVER USED THE FOLLOWING:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 20%; text-align: center;">AMOUNT PER DAY</th> <th style="width: 20%; text-align: center;">NUMBER OF YEARS USED</th> <th style="width: 30%; text-align: center;">IF YOU QUIT, LIST YEAR</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> CIGARETTES</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> CIGARS</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> PIPES</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> CHEW</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> E-CIGARETTES</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		AMOUNT PER DAY	NUMBER OF YEARS USED	IF YOU QUIT, LIST YEAR	<input type="checkbox"/> CIGARETTES	_____	_____	_____	<input type="checkbox"/> CIGARS	_____	_____	_____	<input type="checkbox"/> PIPES	_____	_____	_____	<input type="checkbox"/> CHEW	_____	_____	_____	<input type="checkbox"/> E-CIGARETTES	_____	_____	_____
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<input type="checkbox"/> E-CIGARETTES	_____	_____	_____																						
<p style="text-align: center;">DIABETES</p> <p>Gum disease is a common complication of diabetes. Untreated, gum disease makes it harder for patients with diabetes to control their blood sugar.</p>	<p style="text-align: center;">IF YOU ARE A PATIENT WHO HAS DIABETES</p> <p>1. Is your diabetes under control? <input type="radio"/> YES <input type="radio"/> NO</p> <p>2. Are you prone to diabetic complications? <input type="radio"/> YES <input type="radio"/> NO</p> <p>How do you monitor your blood sugar? _____</p> <p>Who is your physician for diabetes? _____</p> <p style="text-align: center;">IF YOU ARE NOT A PATIENT WHO HAS DIABETES</p> <p>Any family history of diabetes? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Have you had any of these warning signs of diabetes?</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> FREQUENT URINATION</td> <td><input type="checkbox"/> SLOW HEALING OF CUTS</td> <td><input type="checkbox"/> WEAKNESS & FATIGUE</td> </tr> <tr> <td><input type="checkbox"/> EXCESSIVE HUNGER</td> <td><input type="checkbox"/> EXCESSIVE THIRST</td> <td><input type="checkbox"/> UNEXPLAINED WEIGHT LOSS</td> </tr> </table>	<input type="checkbox"/> FREQUENT URINATION	<input type="checkbox"/> SLOW HEALING OF CUTS	<input type="checkbox"/> WEAKNESS & FATIGUE	<input type="checkbox"/> EXCESSIVE HUNGER	<input type="checkbox"/> EXCESSIVE THIRST	<input type="checkbox"/> UNEXPLAINED WEIGHT LOSS																		
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<p style="text-align: center;">HEART ATTACK & STROKE</p> <p>Untreated gum disease may increase your risk for heart attack or stroke.</p>	<p style="text-align: center;">DO YOU HAVE ANY RISK FACTORS FOR HEART DISEASE OR STROKE?</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> FREQUENT URINATION</td> <td><input type="checkbox"/> SLOW HEALING OF CUTS</td> <td><input type="checkbox"/> WEAKNESS & FATIGUE</td> </tr> <tr> <td><input type="checkbox"/> EXCESSIVE HUNGER</td> <td><input type="checkbox"/> EXCESSIVE THIRST</td> <td><input type="checkbox"/> UNEXPLAINED WEIGHT LOSS</td> </tr> </table> <p><i>If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.</i></p>	<input type="checkbox"/> FREQUENT URINATION	<input type="checkbox"/> SLOW HEALING OF CUTS	<input type="checkbox"/> WEAKNESS & FATIGUE	<input type="checkbox"/> EXCESSIVE HUNGER	<input type="checkbox"/> EXCESSIVE THIRST	<input type="checkbox"/> UNEXPLAINED WEIGHT LOSS																		
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<p style="text-align: center;">MEDICATIONS</p> <p>A side effect of some medications can cause changes in your gums.</p>	<p style="text-align: center;">ARE YOU TAKING OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATION?</p> <p>Anti-seizure medications (Dilantin, Tegretol, Phenobarbital, etc.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>If YES, are you still taking the anti-seizure medication? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Name of medication: _____</p> <p>Blood pressure medication (Procardia, Cardizem, Norvasc, Verapamil, etc.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>If YES, are you still taking the blood pressure medication? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Name of medication: _____</p> <p>Immunosuppressant therapy (Prednisone, Azathioprine, Cyclosporins, Corticosteroids, Asthma Inhalers, etc.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>If YES, are you still taking the immunosuppressant medication? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Name of medication: _____</p>																								
<p style="text-align: center;">FAMILY HISTORY & GENETICS</p> <p>The tendency for gum disease to develop can be inherited.</p>	<p>Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. Your mother, father, or siblings) <input type="radio"/> YES <input type="radio"/> NO</p>																								



PERIO RISK ASSESSMENT

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<p>HEART MURMUR OR ARTIFICIAL JOINT PROSTHESIS</p> <p>If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.</p>	<p>DO YOU NOW OR HAVE YOU EVER USED THE FOLLOWING</p> <p>Do you have a heart murmur? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Do you have an artificial joint? <input type="radio"/> YES <input type="radio"/> NO</p> <p>If YES, does your physician recommend antibiotics prior to dental visits? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Name of physician? _____</p> <p><i>If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.</i></p>
<p>FEMALES/WOMEN</p> <p>Females can be at increased risk for gum disease at different points in their lives.</p> <p>Women with osteoporosis have a greater risk for periodontal bone loss.</p>	<p>THE FOLLOWING CAN ADVERSELY AFFECT YOUR GUMS. PLEASE CHECK ALL THAT APPLY.</p> <p><input type="checkbox"/> PREGNANT <input type="checkbox"/> MENOPAUSE <input type="checkbox"/> TAKING BIRTH CONTROL PILLS</p> <p><input type="checkbox"/> NURSING <input type="checkbox"/> INFREQUENT CARE DURING PREVIOUS PREGNANCIES</p> <p>DO YOU TAKE ANY OF THE FOLLOWING?</p> <p>Estrogen Replacement Therapy/Hormone Replacement Therapy (Prempro, Premarin, Premphase, Fosamax, Actonel, Evista, Forteo, etc.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>Name of medication: _____</p>
<p>NUTRITION & STRESS</p> <p>Your diet has the potential to affect your periodontal health.</p> <p>High levels of stress can reduce your body's immune defense.</p>	<p>Are you under a lot of stress? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Do you find it difficult to maintain a well-balanced diet? <input type="radio"/> YES <input type="radio"/> NO</p>
<p>HAVE YOU NOTICED ANY OF THE FOLLOWING SIGNS OF GUM DISEASE?</p> <p><input type="checkbox"/> BLEEDING GUMS DURING TOOTH BRUSHING <input type="checkbox"/> PUS BETWEEN THE TEETH AND GUMS</p> <p><input type="checkbox"/> RED, SWOLLEN OR TENDER GUMS <input type="checkbox"/> LOOSE OR SEPARATING TEETH</p> <p><input type="checkbox"/> GUMS THAT HAVE PULLED AWAY FROM THE TEETH <input type="checkbox"/> CHANGE IN THE WAY YOUR TEETH FIT TOGETHER</p> <p><input type="checkbox"/> PERSISTENT BAD BREATH <input type="checkbox"/> FOOD CATCHING BETWEEN TEETH</p> <p>Is it important to keep your teeth for as long as possible? <input type="radio"/> YES <input type="radio"/> NO</p> <p>If you have missing teeth, why have you not had them replaced? _____</p> <p>Do you like the appearance of your smile? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Do you like the color of your teeth? <input type="radio"/> YES <input type="radio"/> NO</p> <p>Do your teeth keep you from eating any specific food? <input type="radio"/> YES <input type="radio"/> NO</p>	



COSMETIC QUESTIONNAIRE

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We love to create and enhance smiles every day in our practice. In order to evaluate your needs and desires as accurately as possible, please help us by answering the following questions, choose any words that may apply, and provide us with any additional information. If you have NO cosmetic concerns or desires, you may skip this section of the paperwork.

1. Rate your smile on a scale from 1 - 10 with 10 being the best smile: 1 2 3 4 5 6 7 8 9 10
2. How would you describe the color of your teeth? (dull, stained, etc.) _____
3. Are your teeth crooked or out of line? _____ YES NO
4. Are there spaces between your teeth you don't like? _____ YES NO
5. Have the biting edges of your teeth become uneven, worn down, or chipped? _____ YES NO
6. Do you like the appearance of your dental fillings or crowns? _____ YES NO
7. Do your dental fillings or crowns match your other teeth? _____ YES NO
8. Are any of your teeth missing? _____ YES NO
9. Is there anything else about your smile or teeth that you don't like, would like to change, or would like us to know?

STOP HERE!
(Below Portion To Be Completed With Your Dental Hygienist or Dentist)

1. High Smile Line _____	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
2. Deep Bite _____	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
3. Functional Risk with Aesthetic Treatment _____	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
4. Ortho prior to Aesthetic Treatment _____	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
5. Midline to Face _____	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
6. Upper Midline to Lower Midline _____	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
7. Overall Aesthetic Risk _____	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH

COSMETIC NEED LOW MODERATE HIGH



OCCLUSAL RISK ASSESSMENT

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PATIENT NAME	DATE
DO YOU HAVE PROBLEMS WITH YOUR JAW JOINT (PAIN, SOUNDS, LIMITED OPENING, LOCKING, POPPING)?	
DO YOU FEEL LIKE YOUR LOWER JAW IS BEING PUSHED BACK WHEN YOU BITE YOUR TEETH TOGETHER?	
DO YOU AVOID OR HAVE ANY DIFFICULTY CHEWING GUM, CARROTS, NUTS, BAGELS, PROTEIN BARS, OR OTHER HARD, DRY FOODS?	
HAVE YOUR TEETH CHANGED IN THE LAST 5 YEARS (i.e. BECOME SHORTER, THINNER, OR WORN)?	
ARE YOUR TEETH BECOMMING MORE CROWDED OR DEVELOPING MORE SPACES OVER THE LAST 5 YEARS?	
DO YOU KNOW YOURSELF TO HAVE MORE THAN ONE BITE?	
DO YOU CHEW ICE, BITE YOUR NAILS, USE YOUR TEETH TO HOLD THINGS, OR HAVE ANY OTHER CHEWING/BITING HABITS?	
DO YOU CLENCH YOUR TEETH IN THE DAYTIME OR MAKE THEM SORE?	
DO YOU HAVE PROBLEMS WITH SLEEP OR WAKE UP WITH SORENESS OR SENSITIVITY IN YOUR TEETH?	
DO YOU WEAR OR HAVE YOU EVER WORN A BITE APPLIANCE?	
DO YOU CLENCH OR GRIND YOUR TEETH WHEN YOU ARE STRESSED?	
STOP HERE! (Below Portion To Be Completed With Your Dental Hygienist or Dentist)	
1. Significant Wear Present Relative to Age?	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
2. Load Test?	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
3. Constricted Chewing Pattern?	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
4. Anterior Wear?	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
5. Posterior Wear?	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
6. Appliance Therapy Likely?	<input type="radio"/> LOW <input type="radio"/> MOD <input type="radio"/> HIGH
OVERALL OCCLUSAL RISK ASSESSMENT <input type="radio"/> LOW <input type="radio"/> MODERATE <input type="radio"/> HIGH	



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Note: You may refuse to sign this acknowledgment.

I, _____ have received a copy of this office's Notice of Privacy Practices.	
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

FOR OFFICE USE ONLY

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

- INDIVIDUAL REFUSED TO SIGN
- COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT
- AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGMENT
- OTHER (PLEASE SPECIFY): _____

SIGNATURE OF OFFICE REPRESENTATIVE	DATE
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