Chrispens & Evans DDS

PATIENT INFORMATION

PATIENT DENTAL HISTORY Name of Previous Dentist and Location: When were your last dental X-Ray's and where were they taken: How often do you brush your teeth? Which method do you use: Hand brushing Electric toothbrush What other dental products do you use regularly? Have you ever been informed you have periodontal disease? If yes, by whom? Have you had previous periodontal treatment? If yes, when and what treatment? What are your Dental/Periodontal concerns: Do your gums bleed while brushing or flossing? Are your teeth sensitive to sweet or sour liquids/foods? Yes no Do you feel pain to any of your teeth? Wes no Dave you had any head, neck or jaw injuries? Pain (joint, ear, side of face)? Yes no Difficulty in opening or closing? Yes no Difficulty in chewing? Yes ro Difficulty in chewing? Yes ro Difficulty in chewing? Yes ro Date of last dental exam: / / / When: AM PM Which type is it: soft bristle medium bristle hard bristle What PM Which type is it: soft bristle medium bristle hard bristle Pair (joint, ear, side of face)? Yes no If yes, when? / / // When: AM PM Which type is it: soft bristle medium bristle hard bristle ### And PM Which type is it: soft bristle medium bristle ### And PM Which type is it: soft bristle medium bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM Which type is it: soft bristle ### And PM ### And PM ### And PM ### And PM ###	Mr. / Mrs. / Ms.					
City:			Birth Date:	/ /)
SSS; Driver's License #: Expires: / / Are you (please circle one of the following): Single Married Divorced Wildowed Employee: Occupation: Work Address: City: Zip: Physician: City/State: Physician's Phone: () Dentists Phone: () Work Address: City/State: Dentists Phone: () Dentists Phone: () Dentists Phone: () Phone: () Work Phone: () Dentists Phone: () D			acil Address:		Cell Phone: ()
Are you (please circle one of the following): Single Married Divorced Wildowed Employer: Occupation: Virtual					Fy	nires: / /
Employer: Occupation: Work Phone: () Work Address: City: Zip: Physician: City/State: Physician's Phone: () Dentist's Phone: () Nearest Relativer/Friend: Dentist's Saft: Deloy(Group #: Deloy(Group				Widowe		.piros
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Dentists City/State: Dentist's Phone: []			Oity.			Σίγ.
Nearest Relative/Friend: Whom may we thank for your referral? Spouse's Employer: Occupation: Work Phone: (<u> </u>)
Whom may we thank for your referral? Spouse's Name: Birth Date:		City/State.		<u> </u>		
Spouse's Name: Birth Date:					1 Hone. (
Spouse's Employer: Work Address: City: Sign: Do you have dental insurance? (Please circle "yes" or "no") Yes No Primary Subscriber: Subscriber's SS#: Policy/Group #: Insurance Company: Insurance Company: Insurance Company: Insurance Address: City/State: Zip: City/State: Zip: Date of last dental exam: / / When were your last dental X-Ray's and where were they taken: How often do you brush your teeth? Which method do you use: Hand brushing Electric toothbrush What other dental products do you use regularly? Have you ever been informed you have periodontal disease? If yes, by whom? If yes, by whom? If yes, by whom? If yes, by whom and what treatment? Do you freeth sensitive to sweet or sour liquids/floods? Part in July State Stat			Disth Data	1 1	O all Diverse	
Work Address: Do you have dental insurance? (Please circle "yes" or "no") Yes No Primary Subscriber: Subscriber's SS#: Subscriber's SS#: Policy(Group #: Policy	·	Occi		/ /		
Do you have dental insurance? (Please circle "yes" or "no") Yes No Primary Subscriber: Subscriber's SS#: - Subscriber's SS#: - Policy/Group #: Insurance Company: Insurance Company: Insurance Address: Insurance Address: Insurance Phone: () PATIENT DENTAL HISTORY Name of Previous Dentist and Location: When were your last dental X-Ray's and where were they taken: / / When were your last dental X-Ray's and where were they taken: / / When were your last dental A-Ray's and where were they taken: / / Which nethod do you use: Hand brushing Electric toothbrush What other dental products do you use regularly? Have you had previous periodontal treatment? / / If yes, by whom? If yes, when and what treatment? / / What are your Dental/Periodontal concerns: Do your gums bleed while brushing or flossing? Are your teeth sensitive to sweet or sour liquids/foods? yes no Have you had any head, neck or jaw injuries? yes ro Do you have any sores or lumps in your mouth? yes no Do you feel pain to any of your teeth? yes ro Do you clench or grind your teeth? yes no Do you betour lips or cheeks frequently? yes ro Do you clench or grind your teeth? yes no If yes, when? / / If yes, by whom? Have you had only not enter yes no Do you betour lips or cheeks frequently? yes ro Do you clench or grind your teeth? yes no If yes, when? / / If yes, by whom? Have you had onthodontic treatment? yes no If yes, when? / / If yes, by whom? Have you had onthodontic treatment? yes no If yes, when? / / If yes, by whom? Have you had any prolonged bleeding following an extraction? yes no Do you betour teeth? yes ro Do you have dental implants? yes no If yes, when? / / If yes, by whom? Have you have often any prolonged bleeding following an extraction? yes no If yes, when? / / If yes, by whom? Have you had orthodontic treatment? yes no If yes, when? / / If yes, by whom? Do you have dental implants? yes no If yes, w			• —		work Friorie. (
Primary Subscriber: Subscriber's SS#: - Subscriber's SS#: - Policy/Group #: Insurance Company: Insurance Company: Insurance Company: Insurance Address: City/State: Zip:			•			Σιγ.
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Policy/Group #: Insurance Company: Insurance Address: City/State:	· -			-	er:	
Insurance Company: Insurance Address: Insurance Address: Insurance Phone: () PATIENT DENTAL HISTORY Name of Previous Dentist and Location: When were your last dental X-Ray's and where were they taken: How often do you brush your teeth? Which method do you use: Hand brushing Electric toothbrush What other dental products do you use regularly? Have you ever been informed you have periodontal disease? If yes, by whom? Have you bed hile brushing or flossing? Are your teeth sensitive to sweet or sour liquids/foods? Pain (joint, ear, side of face)? Pain (joint, ear, side of						<u> </u>
Insurance Address: City/State: Zip: City/State: Date of last dental exam: // When ere your last dental X-Ray's and where were they taken: // When were your last dental X-Ray's and where were they taken: Which type is it: Soft bristle medium bristle hard bristle What other dental products do you use: Have you ever been informed you have periodontal disease? If yes, by whom? Have you periodontal treatment? When and what treatment? Wes no Are your teeth sensitive to hot or cold liquids/foods? Yes no Do you feel pain to any of your teeth? Pain (joint, ear, side of face)? Pain (joint, ear, side of face)? Yes no Difficulty in opening or closing? Do you brave any anxieties about dental treatment? Yes no Have you have dany prolonged bleeding following an extraction? Have you ever had any prolonged bleeding following an extraction? Do you have any snile? Yes no Hove when? Hyes, when? If yes, by whom? If yes no Do you feel pain to any of your teeth? Yes no Do you brave any sores or lumps in your mouth? Yes no Do you brave any sores or lumps in your mouth? Yes no Do you brave any sores or lumps in your mouth? Yes no Do you brave any sores or lumps in your mouth? Yes no Do you brave any sores or lumps in your mouth? Yes no Do you brave dental implants? Yes no How important is it to you to keep your teeth? Extremely Somewhat Unimportant Do you have any anxieties about dental treatment? Yes no How important is it to you to keep your teeth? Extremely Somewhat Unimportant Are you currently in a regular exercise/physical activity program? Yes no If yes, what?						
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If yes, when and what treatment? / / What are your Dental/Periodontal concerns: Do your gums bleed while brushing or flossing?	Have you ever been informed you have p		yes no	If yes, when?		_
Do your gums bleed while brushing or flossing? Are your teeth sensitive to sweet or sour liquids/foods? Do you have any sores or lumps in your mouth? Have you ever experienced any of the following problems in your jaw: Pain (joint, ear, side of face)? Do you clench or grind your teeth? Have you ever had any prolonged bleeding following an extraction? Have you had orthodontic treatment? Do you have dental implants? Do you like your smile? Do you like your smile? Do you practice stress management? Yes no If yes, what? Are your teeth sensitive to hot or cold liquids/foods? yes no Do you feel pain to any of your teeth? yes no Do you have dany prolonged pleeding following problems in your jaw: Clicking? Yes no Difficulty in chewing? Yes no Do you bite your lips or cheeks frequently? Yes no If yes, when? / / If yes, by whom? Do you like your smile? Do you like your smile? Do you have any anxieties about dental treatment? Yes no If yes, what? Are you currently in a regular exercise/physical activity program? Yes no If yes, what?		nent? yes no	If yes, by whom	1?		
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Pain (joint, ear, side of face)? yes no Difficulty in opening or closing? yes no Difficulty in chewing? yes ro Do you clench or grind your teeth? Yes no Do you bite your lips or cheeks frequently? Yes ro Have you ever had any prolonged bleeding following an extraction? Have you had orthodontic treatment? Yes no If yes, when? / / If yes, by whom? Do you have dental implants? Yes no How important is it to you to keep your teeth? Extremely Somewhat Unimportant Do you have any anxieties about dental treatment? Yes no If yes, what? Are you currently in a regular exercise/physical activity program? Yes no If yes, what?	Do you have any sores or lumps in your	mouth? yes	no Have y	ou had any he	ead, neck or jaw injur	ries? yes
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Do you practice stress management?			_	F , 5 a. 100		
Are you currently in a regular exercise/physical activity program? yes no If yes, what?	•	———				
				If yes what?		
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			PATIENT MEDICAL								
How would you describe your pre	sent he	alth? (Please circle one) Exc	ellent	Goo		on't Know				
Date of last physical exam:	/	/	Hei	ght:		Weight:	lbs				
Are you currently being treated m	edically	?	yes no If yes, please exp	olain:							
Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:											
Have you ever taken Phen-Fen? yes no											
Have you ever taken Redux? yes no											
Do you use tobacco products or smoke?											
Women only: Are you pregnant or think you may be pregnant? yes no If yes, due date: / /											
Are you taking oral contracentives? Ves no What:											
Are you taking oral contraceptives?											
Alcohol	yes	no no	Dental Anesthetics	yes	no	Penicillin	yes no				
	yes	no	Erythromycin	yes	no	Other Antibiotics					
Aspirin Barbiturates/Sedatives			lodine	yes	no	Sulfa Drugs					
	yes	no		=	=	G	yes no				
Codeine	yes	no	Latex	yes	no	Tetracycline	yes no				
Demerol	yes	no	Mint	yes	no	Valium	yes no				
Other Drugs	yes	no	What:								
	ny of th	e foll	owing? (Please mark "yes" or "no	" for ea	ch)						
Heart Disease/Surgery	yes	no									
Heart Attack	yes	no	Heart Murmur	yes	no	Cardiac Pacemaker	yes no				
Chest Pains	yes	no	Congenital Heart Lesion	yes	no	Mitral Valve Prolapse	yes no				
AIDS or HIV	yes	no	Easily winded	yes	no	Lung/Respiratory Problems	yes no				
Anemia	yes	no	Emphysema	yes	no	Nervousness/Anxiety	yes no				
Angina	yes	no	Epilepsy/Convulsions	yes	no	Osteoporosis	yes no				
Arthritis/Rheumatism	yes	no	Excessive thirst	yes	no	Psychiatric Care	yes no				
Asthma/Sinus Problems/Hay Fev	yes	no	Fainting/Seizures	yes	no	Recent weight loss/gain	yes no				
Back problems/surgery	yes	no	Frequent urination	yes	no	Recurrent infections	yes no				
Blood Disease/Disorder	yes	no	Frequently tired	yes	no	Rheumatic Fever	yes no				
Bruise easily	yes	no	Glaucoma	yes	no	Rheumatism	yes no				
Cancer or Tumor	yes	no	Headaches, frequent/severe	yes	no	Scarlet Fever	yes no				
Chemical Dependency	yes	no	Hemophilia	yes	no	Sickle Cell Disease	yes no				
Chemotherapy or Radiation	yes	no	Hepatitis	yes	no	Special Diet	yes no				
Circulatory Problems	yes	no	Herpes/STD's	yes	no	Stroke	yes no				
Cold sores/Fever blisters	yes	no	High Blood Pressure	yes	no	Swollen ankles	yes no				
Colitis	yes	no	Jaundice	yes	no	Tension	yes no				
Contact lenses, do you wear?	yes	no	Jaw pain	yes	no	Thyroid problems	yes no				
Cortisone Treatments	yes	no	Joint Replacement	yes	no	Tonsillitis	yes no				
Cosmetic surgery	yes	no	Kidney Disease/Disorder	yes	no	Tuberculosis	yes no				
Cough, persistent or bloody	yes	no	Leukemia	yes	no	Ulcer yes					
Depression	yes	no	Liver Disease/Disorder	yes	no						
Diabetes	yes	no	Low Blood Pressure	yes	no						
	,										
I certify that I have read and understand the above questions. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my understanding. I will not hold John B Chrispens, DDS, John K. Evans DDS or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. Further, I understand that changes to my appointments may incur charges of up to 50% of the scheduled treatment fee when not made with at least two business days' notice.											

Patient Signature/Responsible Party: Date: / /

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