Cosmetic & Implant Dentistry of Kansas City

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Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Blood Pressure/Pulse (to be take by clinical staff): ______________________

What is the reason for your visit today? ______________________

Previous Dentist Name and Phone Number: ______________________

Evaluation of past dental experience:
○ Good ○ Average ○ Poor

I routinely see my dentist every:
☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ not routinely

Date of most recent dental exam and dental x-rays: ______________________

How would you rate the condition of your mouth?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ○ Yes ○ No

Name of physician or dentist making recommendation and phone number: ______________________

ORAL HEALTH CARE HABITS

What kind of toothbrush do you usually use?
○ Hard ○ Medium ○ Soft ○ Electric

How many times per day do you brush your teeth?
○ <1 ○ 1 ○ 2-3 ○ 4+

How frequently do you floss?
○ Rarely or Never ○ Occasionally (2-6 times per month) ○ Frequently (3-6 times per week) ○ Daily

DENTAL INFORMATION

Check all that apply:

☐ Had complications from past dental treatment
☐ Have dry mouth
☐ Have popping and/or clicking of your jaw joint
☐ Gums bleed when brushing or flossing
☐ Have or had a burning sensation in your mouth
☐ Had trouble getting numb
☐ Teeth are sensitive to hot, cold, biting or sweets
☐ Have difficulty chewing
☐ Have been treated for gum disease
☐ Snore or wake up frequently during the night
☐ Had any reactions to local anesthetic
☐ Food gets trapped between any teeth
☐ Clench or grind your teeth
☐ Have or had gum recession
☐ Would like to change the appearance of your smile
☐ Had or have braces (orthodontic treatment)
☐ Have whitened or bleached your teeth
☐ Wear or have worn a bite appliance
☐ Had an unpleasant taste or odor in your mouth
☐ Claustrophobic

If any of the checked boxes need further explanation, please describe:

____

____

Are your teeth:

☐ Chipped ☐ Protruding ☐ Crooked ☐ Discolored

Are you pleased with the appearance of your teeth when you smile? ◯ Yes ◯ No

Are you satisfied with the color of your teeth? ◯ Yes ◯ No

Are you happy with the shape of your teeth? ◯ Yes ◯ No

Do you like the look of your exisiting dental work? ◯ Yes ◯ No

Do you eat sugary foods, drinks, gum or mints between meals? ◯ Yes ◯ No

Have you ever had a serious injury to your head or mouth? ◯ Yes ◯ No

Please list any other pertinent information regarding your Dental Health:

____

____

HEALTH HISTORY

Are you in good health? ◯ Yes ◯ No

Please list all medications you take (even over the counter):

____

____

Please list all allergies to medications:

____

____

Have you ever been treated with oral or IV Bisphosphonate Medications (i.e., Fosamax (alendronate) or Boniva):

☐ None ☐ IV ☐ Oral ☐ IV and Oral ☐ Taking Currently ☐ Not Taking Currently

Please check the box for any of the following conditions you have or have had

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergy - Aspirin
☐ Allergy - Codeine	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Angina/Chest Pain	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Auto Immune Disorder	☐ Birth Control	☐ Blood Disease
☐ Cancer	☐ Chemotherapy	☐ Cortisone Treatment	☐ Currently Nursing
☐ Currently Pregnant	☐ Depression/Anxiety	☐ Diabetes	☐ Epilepsy/Seizure
☐ Excessive Bleeding	☐ Fainting	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur/MVP	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/AIDS	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ Nervous Disorders	☐ Organ/CellTransplant	☐ Osteoporosis
☐ Pacemaker/Defib	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Seasonal Allergies	☐ Sinus Problems	☐ Sleep Apnea	☐ Stomach Problems
☐ Stroke/TIA	☐ Thyroid Disorder	☐ TMD/TMJ	☐ Tobacco/Vapor Use
☐ Tuberculosis	☐ Ulcers	☐ x - OTHER	

Describe Checked Answers and Include Any Information Not Listed Above:

____

____

Please List Any Hospitalizations-include month/year:

____

____

Is there anything significant about your medical history that has not been addressed on this form? Please describe:

____

____

Are you currently seeing a physician for any reason? If so, please list type of care, name and address of physician:

____

____

Please list preferred pharmacy and pharmacy phone number:

____

____

Do you use tobacco? ◯ Yes ◯ No

Please list tobacco type and frequency/amount of usage if applicable. ____________

If yes, are you interested in receiving information to stop? ◯ Yes ◯ No

How frequently do you consume alcohol?

◯ Rarely or Never ◯ Monthly ◯ Weekly ◯ Daily

How frequently do you use recreational drugs?

◯ Never ◯ Rarely (1-4 times per year) ◯ Infrequently (5-11 times per year) ◯ Occasionally (1-3 times per month)

◯ Frequently (4+ times per month) ◯ Previous usage

Please list type of drug: ____________

☐ * **All information provided is accurate to the best of my knowledge and I will inform the dentist of any updates and/or changes to my health in the future.**

Response Date: ________