The Center for Integrative Dentistry 973-579-7400 FAX 973-579-7459 info@centerforintegrativedentistry.com

Name:_____ Today's Date:_____

Previous Dentist's name:_____

Date of your last dental visit:___/___/___ Why you are changing dentists? _____

_____

Please check all that apply to you:

- ☐ I have lost all my teeth
- ☐ I have lost some of my teeth
- ☐ I have followed my dentist's advice
- ☐ I have teeth that are broken
- ☐ I have teeth that are shifting
- ☐ My gums bleed
- ☐ I may have cavities
- ☐ Dentistry is low on my list of priorities
- ☐ I my present dental health is OK
- ☐ I brush my teeth every day
- ☐ I floss my teeth every day
- ☐ I visit my dentist regularly
- ☐ I have missing teeth
- ☐ I have high quality, long lasting restorations in my mouth.

Please describe any fears about dental care or complications with previous dental treatment,

if any:_____

_____

Are you having any dental discomfort at this time?_____No____Yes (please describe):_____

_____

Do you have teeth that are sensitive to (circle as many as apply to you): HOT COLD SWEETS BITING PRESSURE

If you have crowns, bridgework or dentures, how old is the work? _____years

Are you happy with it?___Yes____ No If no, why?_____

_____

Please check all that apply to you:

- ☐ I have had orthodontics
- ☐ My jaws click or pop sometimes
- ☐ I clench or grind my teeth
- ☐ I get pain or soreness around my ear or facial muscles.
- ☐ I get food caught in between my teeth
- ☐ I have bad breath concerns
- ☐ I get head, neck or shoulder aches
- ☐ I am aware of a sore or growth in my mouth
- ☐ I would change the appearance of my smile if I could.
- ☐ I want whiter teeth
- ☐ I want straighter teeth
- ☐ I want longer teeth
- ☐ I want to close spaces between my teeth

What is the most important results you would like to see from being a patient here?_____

_____

Please check all that apply to you:

- ☐ I want my mouth healthier than it is now
- ☐ If I have to lose some teeth, that's OK
- ☐ I will do anything to keep my teeth

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Should you require a tooth to be restored:

- ☐ It's most important that the restoration last as long as possible.
- ☐ It's most important that the restoration match my own teeth.
- ☐ It's most important that the cost of my care be kept as low as possible, even if that means restoring my teeth in a way that would require a new restoration in the tooth several years later
- ☐ If we find that you require care, is there anything that would keep you from getting started? **If yes, please describe**:

_____

How would you like to be addressed/nickname?_____Date of Birth _____/_____/_____

Home Address: _____Street_____City_____State_____Zip code

Home Phone:_____Cell Phone:_____Work Phone:_____Other:_____
(please circle the phone number you prefer to be contacted on)

Do you have Dental Insurance?___Yes____No Email address: _____

Occupation:_____Company Name:_____Years there:_____

Work Address:_____

Are you currently:_____Single_____Married_____Separated_____Divorced_____Child

Person responsible for payment (if different from above):_____relationship to patient_____

Name of Spouse:_____Names and ages of children:_____

Who to notify in case of emergency?_____Phone #:_____Relationship:_____

How did you hear about our practice?_____

Please indicate the name of the health care provider most familiar with your overall health status:

Provider's name:_____Type of practitioner:_____

Address:_____Phone #:_____

Are you being treated for anything now?___Yes_____No: If yes, please describe:_____

If you are seeing any other health care providers, please list name, type of practice, location, phone # and conditions you are seeing them

For:_____

_____

Please check all that apply to you: Reference the question number, write an explanation in the space to the left. If you need more space, continue on the back. Have you been treated for:

☐ (1) Rheumatic Fever, Mitral Valve Prolapse, Heart Murmur or Congenital heart disease
☐ (2) Heart Attack, Angina, Stroke, Heart Surgery, Pacemaker?
☐ (3) Abnormal Blood Pressure, Anemia or Excessive Bleeding?
☐ (4) Stomach, Intestinal Trouble, Anorexia or Bulimia?
☐ (5) Breathing Problems, Asthma, Tuberculosis or Hay Fever?
☐ (6) Diabetes
☐ (7) Do you smoke or use tobacco products? If yes, amount per day:
☐ (8) Hepatitis, Jaundice or Liver disease?
☐ (9) Kidney Problems?
☐ (10) Venereal Disease, HIV or AIDS?
☐ (11) Convulsions, Fainting Spells or Epilepsy?
☐ (12) Do you consume alcoholic beverages? If yes, amount per day:
☐ (13) Tumors or Growths?
☐ (14) Cancer, X-ray treatments to shrink tumors or Chemotherapy?
☐ (15) Allergic Reactions to medications or other allergies?
☐ (16) Have you ever had a major operation?
☐ (17) Do you drink coffee, tea or caffeinated beverages? Amount per day:
☐ (18) Mental, Emotional or Psychological problems:
☐ (19) Any serious injuries to your face, head or neck?
☐ (20) Women: are you pregnant, suspect you might be or trying to get pregnant?
☐ (21) Percentage of your daily diet consists of fresh fruits, vegetable and whole grains? %
☐ (22) Any health problems that you are aware of?
☐ (23) Current medications (women: include birth control pills) or Nutritional Supplements, i.e. vitamins of any kind?

I have read and honestly answered each of the above questions. I will notify the office of any changes at the first appointment. I understand that I am responsible for all costs of dental treatment and I authorize Dr. Shuch to release health or treatment information to other dentist, specialist or physicians as would benefit my health treatment

_____(Signature of patient or guardian)

If you currently suffer from any chronic disease for which you are taking medication and/or receiving regular professional health care, please fill in the following:

1) How and when did this condition begin?

2) What illness or symptoms indicated the beginning of your current chronic condition? How old were you when it began?

3) What types of treatment (medications, therapies, etc.) were used initially:

4) How did your condition progress to its' present state? Please list milestones, including new symptoms, types of treatment and approximate dates of these milestones. If medications were prescribed, indicate the year you began using that medicine and, if discontinued, the date you stopped.

5) How are you feeling at the present time?