Nathalie Tungesvik, DDS
Mollie Lindquist, DDS

Patient Information

Patient Name ____
Last First Middle Initial Preferred name

Birth Date ______/______/_________ **Social Security Number**______________________________

Family Status: Single ___ Married ___ Child ___ Other ___ **Gender:** Male ___ Female ___

Address____
(Parent/guardian if Minor) Street Apt# City State Zip

Home Ph. ___________________________ **Work Ph.**___________________________ **Cell** ____________________________
(Parent/guardian if Minor)

E-Mail Address____
(Parent/guardian if Minor)

Employer ____________________________________ **Occupation** _______________________________________
(Parent/guardian employer if Minor)

Spouse's Name ____
(Parent/guardian if Minor) Last First Middle Initial

IS AN IMMEDIATE FAMILY MEMBER A PATIENT HERE? Name: ____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____

Emergency Contact____
Name Relationship to Patient Phone

Dental Insurance Information

Name of Insured____ **Relationship to patient**________________________

Social Security Number ______________________________ **Birth Date** ______/______/______

Name of employer_____________________________________ Work Phone_________________________ Ext.____________

Employer Address____
Street City State Zip

Insurance Company______________________________ Group #________________________ Policy/ID #________________________

Ins. Co. Address____
Street City State Zip

We will need a copy of your insurance card at your initial appointment. Please bring your insurance card with you for each appointment.

*****Authorization and Release*****

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. Finance charge or interest of 1.5% a month will be applied to all balances over 90 days past due.
As a service to our clients, we provide a courtesy appointment reminder email and possibly other important emails that may be sent. By providing your email address, you consent to receiving such notifications.

X____
Signature of patient (or parent/guardian if minor) Date

MEDICAL HISTORY

Patient Name ______________________________ Nickname ____________ Age ______
Name of Physician/and their specialty ______________________________
Most recent physical examination ____________________ Purpose ____________________
What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury____________
2. an allergic reaction to
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ________)
   - latex
   - other ____________________
3. heart problems, or cardiac stent within the last six months __
4. history of infective endocarditis ____________
5. artificial heart valve, repaired heart defect (PFO) ______
6. pacemaker or implantable defibrillator ________
7. orthopedic implant (joint replacement)__________
8. rheumatic or scarlet fever______________
9. high or low blood pressure______________
10. a stroke (taking blood thinners) ____________
11. anemia or other blood disorder ____________
12. prolonged bleeding due to a slight cut (INR > 3.5) _____
13. emphysema, shortness of breath, sarcoidosis ______
14. tuberculosis, measles, chicken pox____________
15. asthma ________________________
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____________________
18. liver disease ____________________
19. jaundice ______________________
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency ________________
22. high cholesterol or taking statin drugs __________
23. diabetes (HbA1c =______)______________
24. stomach or duodenal ulcer ____________
25. digestive disorders (i.e. celiac disease, gastric reflux) _____
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __

YES NO

27. arthritis ______________________
28. autoimmune disease ________________
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ______________________
30. contact lenses ____________________
31. head or neck injuries ________________
32. epilepsy, convulsions (seizures) ____________
33. neurologic disorders (ADD/ADHD, prion disease) _____
34. viral infections and cold sores ____________
35. any lumps or swelling in the mouth__________
36. hives, skin rash, hay fever______________
37. STI / STD / HPV __________________
38. hepatitis (type ___) ________________
39. HIV / AIDS ______________________
40. tumor, abnormal growth______________
41. radiation therapy__________________
42. chemotherapy, immunosuppressive medication _____
43. emotional difficulties______________
44. psychiatric treatment______________
45. antidepressant medication ____________
46. alcohol / recreational drug use ____________

ARE YOU:

47. presently being treated for any other illness ______
48. aware of a change in your health in the last 24 hours
    (i.e. fever, chills, new cough, or diarrhea) ______
49. taking medication for weight management ______
50. taking dietary supplements ____________
51. often exhausted or fatigued ____________
52. experiencing frequent headaches__________
53. a smoker, smoked previously or use smokeless tobacco _
54. considered a touchy / sensitive person ________
55. often unhappy or depressed ____________
56. FEMALE - taking birth control pills __________
57. FEMALE - pregnant ________________
58. MALE - prostate disorders ______________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ____________
Doctor's Signature ______________________________ Date ____________

ASA ______ (1-6)

DENTAL HISTORY

Name________________________________ Nickname_______________________________ Age__________
Referred by____________________________How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist ________________________________How long have you been a patient?___________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ________________________________
2. Have you had an unfavorable dental experience? ________________________________
3. Have you ever had complications from past dental treatment? ________________________________
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ________________________________
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ________________________________
6. Have you had any teeth removed or missing teeth that never developed? ________________________________

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ________________________________
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________________________________
9. Have you ever noticed an unpleasant taste or odor in your mouth? ________________________________
10. Is there anyone with a history of periodontal disease in your family? ________________________________
11. Have you ever experienced gum recession? ________________________________
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____________
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ________________________________

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ________________________________
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ________________________________
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________________________________
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ________________________________
18. Do you have grooves or notches on your teeth near the gum line? ________________________________
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________________________________
20. Do you frequently get food caught between any teeth? ________________________________

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ________________________________
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ________________________________
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____________
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ________________________________
25. Are your teeth becoming more crooked, crowded, or overlapped? ________________________________
26. Are your teeth developing spaces or becoming more loose? ________________________________
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ________________________________
28. Do you place your tongue between your teeth or close your teeth against your tongue? ________________________________
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________________________________
30. Do you clench your teeth in the daytime or make them sore? ________________________________
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ________________
32. Do you wear or have you ever worn a bite appliance? ________________________________

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? ________________________________
34. Have you ever whitened (bleached) your teeth? ________________________________
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ________________________________
36. Have you been disappointed with the appearance of previous dental work? ________________________________

Patient's Signature ____ Date________________________

Doctor's Signature ____ Date ________________________

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