HEBERT DENTAL

Today's Date _____

Name _____ Birthday _____ Age _____
First Last Preferred Name

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Email Address _____ Social Security # _____

Employed by _____Phone _____

Present Position _____ May we call you at work? _____

Spouse _____

How did you hear about us? _____

DENTAL HISTORY

What is most important to you when choosing a dentist? _____

What is most important to you in your dental health? _____

Have you ever had any dental experience that was upsetting to you? ☐ Yes ☐ No

Why? _____

Why did you leave your previous dental office? _____

Does dental treatment make you nervous? ☐ No ☐ Yes, moderately ☐ Yes, extremely

What are you expecting to have done today? _____

Date of last dental visit (approximately): _____

Have you been treated for periodontal disease (gum disease)? ☐ No ☐ Yes. If yes, when? _____

Do you have any of the following?

Wear a night guard (splint)	☐ Yes	☐ No	Difficulty opening or closing jaw	☐ Yes	☐ No
Toothache	☐ Yes	☐ No	Sensitive teeth	☐ Yes	☐ No
Places where food catches	☐ Yes	☐ No	Broken tooth/teeth	☐ Yes	☐ No

Concerns about any teeth? _____

Is there anything you would change about your smile? _____

Are you interested in whitening your teeth? ☐ Yes ☐ No

Have you ever had orthodontics (braces or Invisalign)? ☐ Yes ☐ No If yes, when? _____

Would you like to find out more information about a snoring/ sleep apnea appliance? ☐ Yes ☐ No

Do you have any interest in having your mouth free of amalgam (mercury, silver) fillings? ☐ Yes ☐ No

MEDICAL HISTORY

Are you in good health now? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No

If yes, please explain _____

Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No

If yes, please explain _____

Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No

If yes, please give due date _____

Do you smoke or use smokeless tobacco? ☐ Yes ☐ No

How many cigarettes per day? _____ For how many years? _____

Has your physician or dentist ever told you that you need to be on antibiotics (penicillin, etc.) before dental treatment? ☐ Yes ☐ No

Do you have or have you ever had any of the following?

Convulsions/epilepsy	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Heart attack/trouble	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Congenital heart disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Artificial heart valve	☐ Yes	☐ No
AIDS	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart surgery / Heart stent	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No	Infective endocarditis	☐ Yes	☐ No

Physician's name _____ Phone _____

Are you taking any of the following medications?

Blood pressure medication	☐ Yes	☐ No	Tranquilizers	☐ Yes	☐ No
Insulin/other diabetic drugs	☐ Yes	☐ No	Digitalis	☐ Yes	☐ No
Nitroglycerin	☐ Yes	☐ No	Other heart medications	☐ Yes	☐ No

Please list any medications not listed above: _____

Please list any known allergies (i.e. peanuts, tomatoes, gluten, shrimp, etc.): _____

Please list any known allergies to medications: _____

Are you presently taking any type of nutritional supplement such as vitamins, herbs amino acids, fish oils, etc.? ☐ Yes ☐ No

Is there any disease, condition or problem not listed above that you think we should know about?

_____

Other Thoughts: _____

Is there any activity your doctor says you cannot do? Explain: _____

_____

☐ I grant authority to Hebert Dental and its practice auxiliaries to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics, that are deemed necessary and advisable. Patient and/ or legal guardian/parent will be informed before treatment is performed.

☐ I consent to the taking of photographs and videos before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

☐ I'm aware that information shared for continuation of care will be sent electronically. Although all efforts are taken to protect patient information, I understand that information sent via email may be intercepted by third parties. I understand and accept the potential risks involved.

Authorized signature: _____ Date _____