JOURDAIN DENTAL CARE

Medical Information
Dental Information

Dental Health History

Are you happy with your smile? ☐ Yes ☐ No
Please elaborate: _____

Is there anything you would like to change? ☐ Yes ☐ No

Have you ever had any serious problem related to dental treatment?
☐ Yes ☐ No
If yes, please explain: _____

Are you worried or fearful with regards to dental work?
☐ Yes ☐ No

What, if anything, has happened in previous experiences at the dentist that was a reason not to return to that office? _____

Do you have sensitive teeth? ☐ Yes ☐ No
If yes, where? ☐ Upper ☐ Lower ☐ Right ☐ Left
Sensitive to what? ☐ Hot ☐ Cold ☐ Sweet ☐ Pressure

Do you notice excessive bleeding from the gums? ☐ Yes ☐ No
If yes, where? ☐ Upper ☐ Lower ☐ Right ☐ Left

Do you have missing teeth that have not been replaced? ☐ Yes ☐ No
Are you interesting in information on how to replace them? ☐ Yes ☐ No

How often do you brush your teeth? _____
How often do you floss your teeth? _____

Have you ever had braces or been treated for TMJ problems? ☐ Yes ☐ No
Do you have frequent cavity problems? ☐ Yes ☐ No

Do you use any mouth rinses? ☐ Yes ☐ No
Do you lose, or break, fillings/crowns? ☐ Yes ☐ No

Do you have any of the following habits? ☐ Mouth Breathing ☐ Grinding ☐ Gum Chewing ☐ Clenching

We respect your right to choose the level of care that fits your needs. With your permission, we would like to explain the choices available to achieve long-term heath for you and your existing teeth. **Please check all of the following that apply to you:**

☐ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
☐ Spreading payments out over time may help me to achieve the results I desire.
☐ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the results I desire.
☐ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
☐ Although I am not interested in a plan for long-term dental health, I do desire an office that will treat teeth in need of immediate/emergency attention.

Medical Health History

Please answer to the following medical history questions to the best of your ability by checking the appropriate box. All answers given are for our records only and will be kept in the strictest confidence. Do you have, or have you had any of the following? Please check all of those that apply.

☐ Serious Illness/Operation	☐ Trauma to the Face/Jaw	☐ Abnormal Bleeding	☐ Reactions to Local Anesthetic
☐ Currently Taking Medications	☐ Frequent Headaches	☐ Blood Transfusion	☐ Allergies to any Materials
☐ Taken Steroids in Last 2 Yrs	☐ Artificial Joints	☐ Blood Disorders (eg. Anemia)	☐ Allergies to any Medications
☐ Radiation Therapy	☐ Chemotherapy	☐ Pacemaker	☐ Blood Thinners
☐ Rheumatic Fever	☐ Heart Attack	☐ High/Low Blood Pressure	☐ Heart Murmur
☐ Stroke	☐ Convulsions/Seizure Disorder	☐ Stomach Issues (eg. Ulcers)	☐ Fainting/Dizziness
☐ Mental/Nervous Disorders	☐ Asthma	☐ Tuberculosis	☐ Chronic Bronchitis
☐ Emphysema	☐ COPD	☐ Liver Disease	☐ Thyroid Problems
☐ Diabetes	☐ Kidney Disease	☐ Sinus Problems	☐ HIV or AIDS
☐ Sexually Transmitted Disease	☐ Hepatitis A, B, or C	☐ Substance Abuse	☐ Smoker

For Women Only

☐ Currently Pregnant Due Date: _____ ☐ Currently Nursing ☐ Taking Birth Control Pills

If there any conditions that require further clarification, please use the space below:

_____

_____

_____

Staff Signature: _____