



*Twohig Dentistry Dental and Oral Health Information*

Patient's name: \_\_\_\_\_

Date: \_\_\_\_\_

Please describe any specific dental problem or discomfort you are having at this time:

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How long has it been present? \_\_\_\_\_

If you have had any of the following dental care, please list the dentists and approximate dates:

- Periodontal (gum) treatment or surgery: \_\_\_\_\_
- "Braces" or any type of orthodontic treatment: \_\_\_\_\_
- Dental implants: \_\_\_\_\_
- Any other type of oral surgery: \_\_\_\_\_

Your Dental Health:

- How do you rate your overall dental health? \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor
- How many times a day do you brush your teeth? \_\_\_\_\_
- How many times a week do you floss your teeth? \_\_\_\_\_

Do you have/ have you had/ have you noticed any of the following signs or symptoms in your head, neck, or mouth? (Please check Yes or No for each question):

	Yes	No
Teeth that are sensitive to hot, cold, sweets, or biting pressure?		
A clicking, snapping or difficulty when chewing?		
An unpleasant taste or persistent bad breath?		
Difficulty opening or moving the jaws?		
Does food catch between your teeth?		
Difficulty speaking or changes in your voice?		
Do your gums bleed when brushing?		
Difficulty moving your tongue or "tongue tied"?		
Red, swollen, tender, bleeding, or sore gums?		
Loose or separating teeth?		
Gums that have pulled away from the teeth?		
Changes in the way your teeth fit together?		
Pus between the teeth and gums?		
A color change of the tissue in your mouth?		
Avoid any area when brushing or chewing?		
Pain, tenderness, numbness or earaches?		
Do you clench or grind your teeth?		
Any lumps, swelling, or swollen glands?		
Sores, ulcers, or rough spots?		
Do you snore?		

If you are a new patient to the practice:

- Date of last dental visit? \_\_\_\_\_
- Dentist name? \_\_\_\_\_
- City and state? \_\_\_\_\_



**Do you use any of the following? (Please check Yes or No for each question)**

	Yes	No
Mechanical (electric) toothbrush?		
If yes, which type or brand?		
Flossing aids (floss holder, threaders, etc.)?		
Waterpik?		
Fluoride treatments or supplementals at home?		
If yes, which ones?		
Mouthwash or oral rinses?		
If yes, what brand?		

**Please check Yes or No for each question:**

	Yes	No
Do you have any missing teeth that have not been replaced?		
If so, why have you decided to not replace them?		
Do you wear any removable dental appliances (dentures, partials, ortho, etc.)?		
If yes, what type and for how long?		
Have you ever had your teeth whitened or bleached?		
Would you like to have your teeth whitened or bleached?		
How do you feel about the appearance of your teeth?		
What would you change if you could?		
Are the finances required to return your mouth to excellent health a concern?		
Do you feel you always need something treated or repaired when you visit a dentist?		
Do you feel you will eventually wear dentures?		
Have you ever had any complications from an extraction or dental treatment?		
If yes, please explain.		
Have you ever had any major trauma or injury to your head, neck, or mouth?		
If yes, please explain.		



# TWOHIG DENTISTRY

## Health Information and History

Patient's name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

If you are completing this form for another person:

- Your Name: \_\_\_\_\_
- Phone: \_\_\_\_\_
- Relationship: \_\_\_\_\_

Emergency Contact Information (if not same as listed above):

- Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Relationship: \_\_\_\_\_

Primary Physician:

- Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- City and State \_\_\_\_\_

Other Physician & Specialists:

- Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- City and State \_\_\_\_\_

Other Physician & Specialists:

- Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- City and State \_\_\_\_\_

Please check Yes or No to the following questions.

	Yes	No
Within the last 3 years, have you been hospitalized or had surgery?		
If yes, please give reasons and dates:		
_____		
Have you ever been instructed to take any medications or take any special precautions before any dental appointments?		
If yes, please explain.		
Are you taking any drugs, medications, or treatments at this time?		
(If you brought a complete list, please give to the receptionist instead)		
Prescribed:		
Prescribed:		
Prescribed:		
Over the counter medications (Aspirin, allergy medication, sleep aids, etc.)?		
Are you having or have you ever had radiation or chemotherapy treatments?		
Are you taking or have you ever been treated with Bisphosphonates (i.e. Fosamax)?		
Are you allergic to or have you ever had any unusual reaction to:		
Latex?		
Fluoride?		
Metals or Jewelry?		
Nitrous Oxide (laughing gas)?		
Dental Anesthesia?		
General Anesthesia?		



# TWOHIG DENTISTRY

## Health Information and History (continued)

Patient's Name: \_\_\_\_\_

Do you have, or have you ever had any of the following? (Check YES or NO for each question)

	Yes	No		Yes	No
Rheumatic heart disease?			Arthritis?		
Rheumatic fever?			Glaucoma or any eye disease?		
Heart murmur?			Epilepsy or other seizure disorder?		
Heart valve(s) damage?			Any kidney problems?		
Mitral valve prolapse?			Ulcers, acid reflux, or stomach problems?		
Artificial heart valve?			A compromised immune system (Lupus, HIV, AIDS, radiation, immune problems, etc.)?		
Pacemaker?			An active sexually transmitted disease (STD)?		
Stroke or CVA?			Any mental health issues?		
High blood pressure?			Treatment for any psychiatric condition?		
Low blood pressure?			Anemia?		
Hepatitis, jaundice, or other liver problems?			Any artificial joint, joint surgery, or prosthesis?		
Hemophilia or bleeding disorder?			If yes, what joint area?		
Excessive bleeding from any cut or incident?			When was the operation?		
Diabetes or blood sugar problems?					
Any form of cancer?					
Any organ transplant?					
Sleep apnea?					
<b>For women only:</b>					
Are you pregnant?			Do you think you might be pregnant?		
If yes, what is your due date?			Are you using birth control medication?		
Are you taking hormone replacement therapy?					

Are you allergic to any medications \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list medications:

\_\_\_\_\_

Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



*Oral Health Risk Factors*

Patient's Name: \_\_\_\_\_

Please answer the questions below. (Check YES or NO for each question, where applicable)

	Yes	No
1. Do you smoke, or have you ever smoked?		
If no, proceed to question 2.		
The amount that you are presently smoking (check all that apply)		
None (quit smoking completely)		
An occasional cigar	An occasional cigarette	
Less than 1 pack of cigarettes per day	A few cigarettes per day	
1-2 packs of cigarettes per day	2 or more packs per day	
Cigars on a daily/regular basis	Occasional pipe smoker	
A pipe on a daily/regular basis		
If you have quit smoking, when did you quit?		
How many years have you or did you smoke?		
2. Did you/have you EVER chew/chewed tobacco or use/used snuff or other similar substances (if no, proceed to question 3)		
Are you still using smokeless tobacco or snuff?		
When did you quit?		
How many years did you use or have you used smokeless tobacco?		
3. Approximate average amount of alcoholic beverages presently consumed per week?		
None		
Less than 1 per week	1-5 drinks	6-11 drinks
11-20 drinks	over 20 drinks	
4. Do you have or have you ever had a substance abuse problem?		
If yes, please describe:		
5. Do you presently use any recreational drugs?		
List:		
6. Do you have or have you ever had an eating disorder?		
If yes, please describe:		
7. Do you have or have you ever had any head, neck, or mouth piercings?		
List:		
8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possibly cancer causing) of the Human Papilloma Virus (HPV)?		
9. Please list your history or any family member's history of cancer:		

CONSENT- To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further written notice.

I understand there are no guarantees or warranties in health or dental care.

Signature \_\_\_\_\_  
(Parent or guardian, if patient is a minor)

Date: \_\_\_\_\_



***Patient Information***

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Family Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Birth date: \_\_\_\_\_ Phone: home \_\_\_\_\_ cell \_\_\_\_\_ work \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

Do you have a preference in treating doctor? \_\_\_\_\_

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***Spouse or Responsible Party Information***

Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_

Birth date : \_\_\_\_\_ Email address: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

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***Employment Information***

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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***Primary Insurance Information***

Primary Dental Insurance:

Name of Insured: \_\_\_\_\_

Insured's Birth date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Relationship to insured: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_



Secondary Insurance Information:

Name of Insured: \_\_\_\_\_

Insured's Birth date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Employer Address for Secondary Insurance: \_\_\_\_\_

Patient's Relationship to insured: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

\_\_\_\_\_

***Consent for Services:***

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctors to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I give my permission for the doctors or the staff to leave messages on my answering machine regarding my dental care.

I give my permission for the doctors or the staff to leave a message regarding my dental care with a spouse of family member at the number supplied by me.

I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports, may be obtained.

Signature of patient, parent, or guardian (responsible party):

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



**TWOHIG**  
D E N T I S T R Y

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www.TwohigDentistry.com

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_ By my signature below, certify I have received a copy of this dental office's notice of privacy practices.

Patient Name (Print) \_\_\_\_\_

Personal Representative: (Print) \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: You may refuse to sign this form.

If the signature is not obtained, the office must provide the following information.

We attempted to obtain a written Acknowledgement of Receipt of our Notice of Privacy Practices but were unable to due to:

- ( ) The patient (or personal representative refused to sign
- ( ) Inability to communicate (communication problems)
- ( ) Emergency situation
- ( ) Other (Please specify) \_\_\_\_\_

