



Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number

Today's date
First name Middle initial Last name
I prefer to be called (nickname, etc.) Male Female
Address City State ZIP
Date of birth Social security no.
Home phone Work phone Cell phone
Primary contact number (please check one) Home Work Cell Best time to call
Fax E-mail Driver's license no.
Employer Occupation
Spouse's name Spouse's employer
Whom may we thank for referring you?

If the patient is a child

School School phone Grade

Dental History

Reason for today's visit
Are you currently in pain? Yes No
If so, please describe:
Do you have any dental problems now? Yes No
If so, please describe:
Have you ever had trouble with a previous dental treatment? Yes No
If so, please describe:
Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam Date of last cleaning Date of last full mouth X-rays
Procedure(s) done at last dental visit
Previous dentist's name
City State Phone
Why are you changing dentists?

How often do you have dental examinations? How often do you brush your teeth?
How often do you floss? What type of bristles do you use? Hard Medium Soft
What other dental aids do you use? (Electric toothbrush, toothpick, etc.)

Do you require antibiotics before dental treatment? Yes No
Do your gums ever bleed? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you bite your lips or cheeks frequently? Yes No
Do you have frequent headaches? Yes No
Do you clench or grind your teeth? Yes No
Are your teeth sensitive to heat/cold? Yes No
Do you still have your wisdom teeth? Yes No

Have you ever had:

- | | | | |
|-----------------------------------|----------------------------------------------------------|----------------------------------------|----------------------------------------------------------|
| Periodontal disease/gum treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Discomfort in your jaw joint (TMJ/TMD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Orthodontics treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Your teeth ground or bite adjusted | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Oral surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Serious injury to the mouth or head | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A bite plate or mouth guard | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? Yes No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? Yes No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) Yes No

If yes, please explain _____

Have you ever taken Fen-Phen? Yes No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? Yes No

If so, what are the problems? _____

Do you use tobacco? Yes No **Do you use alcohol or any other controlled substance?** Yes No

Women only:

Are you pregnant or think you may be pregnant? Yes No Are you nursing? Yes No

Are you taking birth control pills? Yes No

Indicate which of the following you have had or have at present:

- | | | | | | |
|---------------------------|----------------------------------------------------------|----------------------------------|----------------------------------------------------------|----------------------------|----------------------------------------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol/Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies or Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness/Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/ | |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychological Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Bones/Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles/Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease/Traits | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Snoring/Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | High or Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Problems/ Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospitalized for Any Reason | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (TB) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (Special/Restricted) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Venereal Disease/STD | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction to any of the following:

- | | | | | | |
|------------------------------|----------------------------------------------------------|---------------------------------|----------------------------------------------------------|--------------|----------------------------------------------------------|
| Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedatives | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jewelry/Metals | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa Drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anesthetics (i.e. Novocaine) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Erythromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or Other Antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |

Patient signature _____



Dental Insurance

Primary Carrier

Insurance co. name Insurance co. phone
Address (Street, City, State, ZIP)
Group no. (Plan or Policy no.) Insured's I.D. no.
Insured's name Relationship to patient
Date of birth Insured's social security no.
Insured's employer name Is insured a patient in our practice? Yes No

Secondary Carrier

Insurance co. name Insurance co. phone
Address (Street, City, State, ZIP)
Group no. (Plan or Policy no.) Insured's I.D. no.
Insured's name Relationship to patient
Date of birth Insured's social security no.
Insured's employer name Is insured a patient in our practice? Yes No

Person Financially Responsible for Account

Name Relationship to patient
Social security no. Phone () -
Driver's license no. Date of birth
Address (Street, City, State, ZIP)
Employer Work phone () -
Preferred payment method: Cash Credit Card Check
Visa/MC/AMEX no. Exp. date
If patient is a minor, name of parent or legal guardian and relationship
Is this parent or legal guardian currently a patient in our office? Yes No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature Date

Person to contact in case of emergency

Name Relationship
City State Cell phone
Home phone Work phone

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date Initials

Today's date _____

Patient Number _____

1. Do you love the way your smile looks? Yes No

2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No

3. If you could change anything about your smile, it would be (check all that apply):

- Color of your teeth
- Too much or too little of teeth show when you smile
- Gaps between your teeth
- Size/Shape of your teeth
- Too much or too little of gum shows when you smile
- Alignment of your teeth
- Other: _____

4. Do you have (check all that apply):

- Sensitive or receding gums
- Worn/broken/chipped teeth
- Old or discolored fillings
- Missing teeth
- Old crowns that have dark edges at the top
- Other: _____

5. In your line of work or lifestyle, do you (check all that apply):

- Visit businesses or clients
- Travel
- Speak publicly
- Other: _____

6. If you had a smile makeover do you think you'd feel (check all that apply):

- More confident
- More optimistic
- Healthier
- Just OK
- No different
- Other: _____

7. Do you or someone in your family have issues with any of the following (check all that apply):

- Chronic bad breath
- Grinding teeth
- Snoring
- Other: _____

We'd like to know more about you so we can better serve you!

8. Do you prefer appointments in the (check all that apply):

- Early morning
- Early afternoon
- No preference
- Late morning
- Late afternoon
- Other: _____

9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

10. What type(s) of music do you enjoy? (check all that apply)

- Easy Listening
- Classical
- Rock
- Hip-Hop/Rap
- Jazz
- Country
- R&B
- Other: _____

11. What are your favorite hobbies or activities?

12. Do you have children and grandchildren? If so, please list their names and ages.

13. Is there anything else that you want our office to know about you that will help us to serve you better?



Health History Update

N. Peter Hjorth, DMD
Serving the North Shore for Over 25 Years

Today's date Patient Number
First name Middle initial Last name
Address City State ZIP
Home phone Work Cell
E-mail Fax

Anything else we should know?

Health changes since last visit: Date health change occurred

Physician's name Physician's phone

Current medications

Last physical exam Any allergies?

Patient signature Staff initials Date

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