Infinity DENTAL

(Please Print)

Patient First Name | Patient Last Name | Date

**Please check Yes or No for those that apply to you.**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Sensitivity to: Hot Cold Sweet |
| ☐ | ☐ | Chipped / Broken Teeth |
| ☐ | ☐ | Crooked or Tipped Teeth |
| ☐ | ☐ | Loose Teeth |
| ☐ | ☐ | Missing or Spaces Between Teeth |
| ☐ | ☐ | Catch Food Between Teeth |
| ☐ | ☐ | Dry Mouth or Constantly Thirsty |
| ☐ | ☐ | Smoke or Use Chewing Tobacco |

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Bleeding, Swollen or Irritated Gums |
| ☐ | ☐ | Dissatisfied With Appearance of My Teeth |
| ☐ | ☐ | Frequent Headaches |
| ☐ | ☐ | Jaw Joint Pain |
| ☐ | ☐ | Grinding or Clenching Teeth |
| ☐ | ☐ | Uncomfortable or Uneven When I Bite My Teeth Together |
| ☐ | ☐ | Clicking or Popping of Jaw |
| ☐ | ☐ | Difficulty Opening or Chewing |

**Please check Yes or No if you have, or have had any of the**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Dentures or Partials |
| ☐ | ☐ | Braces or Clear Braces |
| ☐ | ☐ | Periodontal Disease or Gum Treatments |
| ☐ | ☐ | Fixed Bridge |
| ☐ | ☐ | Dental Implants |

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Veneers |
| ☐ | ☐ | Jaw Surgery |
| ☐ | ☐ | Root Canals |
| ☐ | ☐ | Sleep Apnea |
| ☐ | ☐ | C-PAP Machine or Oral Sleep Appliance |
| ☐ | ☐ | Fear or Anxiety About Dental Treatment |

**If I could change my smile, I would:**

☐ Make My Teeth Whiter
☐ Make My Teeth Straighter
☐ Close Spaces or Gaps That Bother Me
☐ Replace Dark Metal Fillings With Tooth Colored Fillings
☐ Fix My Teeth So I'm Not Embarrassed When I Smile
☐ Repair Chipped Teeth
☐ Replace Missing Teeth
☐ Replace Old Crowns That Look Dark or Don't Match
☐ Have a Smile Makeover
☐ Stop My Jaw From Hurting or Clicking

**On a scale of 1 – 10, with 10 being the highest rating:**

How important is your dental health to you? . . . . . . . 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? . . . . . . . 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No
Have you ever been sedated for dental treatment? ☐ Yes ☐ No
Are you interested in sedation options? ☐ Yes ☐ No
If you could whiten your teeth for a investment anyone could afford, would you be interested? ☐ Yes ☐ No
Are you interested in whitening your teeth? ☐ Yes ☐ No

**If this is your first time in our office please answer the following:**

What is the most important thing to you about your dental visit today: ______________________

Why did you leave your previous dentist? ______________________

(Please Print)

Patient First Name | Patient Last Name | Date

Address | Email | Phone

**Please check Yes or No for those that apply to you.**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Artificial Heart Valve |
| ☐ | ☐ | Artificial Joints |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Blood Disease |
| ☐ | ☐ | Bruise Easily |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Chemotherapy |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Low Blood Pressure |
| ☐ | ☐ | Mitral Valve Prolapse |
| ☐ | ☐ | Nervousness / Depression |
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Periodontal Disease |
| ☐ | ☐ | Radiation (Head / Neck) |
| ☐ | ☐ | Respiratory Problems |
| ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Rheumatism |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Stomach Problems |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Ulcers |
| ☐ | ☐ | Venereal Disease |

***Women Only***

| YES | NO | |
|---|---|---|
| ☐ | ☐ | *Birth Control* |
| ☐ | ☐ | *Nursing* |
| ☐ | ☐ | *Pregnant*: |

*Delivery Date*: ___________

**Do you have any of the following drug allergies?**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Darvon |
| ☐ | ☐ | Erythromycin |
| ☐ | ☐ | Percodan |
| ☐ | ☐ | Penicillin |
| ☐ | ☐ | Antibiotics |
| ☐ | ☐ | Other Allergies |

Please list other allergies.

______________________________

______________________________

______________________________

**Please check any of the following drugs you have used at any time:**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Fosamax |
| ☐ | ☐ | Aredia |
| ☐ | ☐ | Zometa |
| ☐ | ☐ | Skelid |
| ☐ | ☐ | Boniva |
| ☐ | ☐ | Bisphosphonates |

**List ALL medications you**

______________________ ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

**Using The Epworth Sleepiness Scale of 0 – 3 How likely are you to doze off or fall asleep in the following situations?**
**No chance of dozing = 0 Slight chance of dozing = 1**
**Moderate chance of dozing = 2 High chance of dozing = 3**

__ Sitting and Reading
__ Watching TV
__ Sitting inactive in a public place, ie... theater or a meeting
__ Lying down to rest in the afternoon if conditions permit
__ Sitting and talking to someone
__ Sitting quietly after lunch without alcohol
__ In a car, while stopped for a few minutes in traffic
__ **TOTAL SCORE**

If under physicians care please explain? ______________________________

______________________________________________

Physician's Name: ______________________________

Physician's Phone: ______________________________

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify INFINITY DENTAL PLLC of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold INFINITY DENTAL PLLC or its employees liable in the event of death or injury.