Yogi Dental
30 Scotland Rd Orange NJ 07050
yogidental@gmail.com
973-673-1311

DENTAL HISTORY AND CONSENT FOR TREATMENT

Reason for seeking dental care at this time _____

Date of last dental visit _____ Reason? _____ Date of last X-rays _____

Former dentist _____ City/state _____

How often do you: **Brush** _____ times per _____ **Floss** _____ times per _____

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

☐Aching or sensitive teeth	☐Broken filling	☐Areas of food traps	☐Unfavorable dental experience
☐Sensitive or bleeding gums	☐Loose teeth	☐Difficulty opening wide	☐Growths or lesions in your mouth
☐Broken or missing teeth	☐Bad breath	☐Clicking or popping in jaw	☐Cold sores
☐Grinding or clenching	☐Swollen glands	☐Jaw pain or tiredness	☐Dry mouth
☐Swelling or lumps in mouth	☐Gum infection	☐Orthodontic treatment	☐Other _____

If you could change your smile, what would you change?

☐Remove unsightly fillings	☐Straighten teeth	☐Change shape of teeth	☐Close gaps between teeth
☐Replace missing teeth	☐Whitening	☐Make teeth same color	☐Other _____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of patient or authorized responsible party	Relationship	Date

DENTAL HISTORY AND CONSENT FOR TREATMENT

Dental health history

Do you have or have you had any of the following?
(check all that apply)

- ☐ Apprehension about dental treatment
- ☐ Problems with previous dental treatment
- ☐ Gag easily
- ☐ Wear dentures
- ☐ Food catches between your teeth
- ☐ Difficulty chewing your food
- ☐ Chew on only one side of your mouth
- ☐ Avoid brushing any part of your mouth because of pain
- ☐ Gums bleed easily
- ☐ Gums bleed when flossing
- ☐ Gums feel swollen or tender
- ☐ Notice slow-healing sores in or around your mouth
- ☐ Feel twinges of pain when your teeth come into contact with:
    - ☐ Hot foods or liquids
    - ☐ Cold foods or liquids
    - ☐ Sour foods
    - ☐ Sweet foods
- ☐ Take fluoride supplements
- ☐ Feel dissatisfied with the appearance of your teeth
- ☐ Want to save your teeth?
- ☐ Want complete dental care?

    How often do you brush? _____
    How often to you floss? _____
- ☐ Your jaw makes noise so that it bothers you
    - ☐ Or others
- ☐ Clench or grind your teeth frequently
- ☐ Jaws feel tired
- ☐ Jaw gets stuck so that you can't open freely
- ☐ Pain when you chew or open wide to take a bite
- ☐ Earaches or pain in front of your ears
- ☐ Jaw symptoms or headaches upon awaking in the morning
- ☐ Jaw pain or discomfort affecting your appetite, sleep, daily routine, or other activities
- ☐ Jaw pain or discomfort that is extremely frustrating or depressing
- ☐ Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)
- ☐ Temporomandibular (jaw) disorder (TMD)
- ☐ Pain in the face, cheeks, jaws, joints, throat, or temples
- ☐ Unable to open your mouth as far as you want
- ☐ Aware of an uncomfortable bite
- ☐ Had a blow to the jaw (trauma)
- ☐ Habitually chew gum?
- ☐ Smoke a pipe?
- ☐ Use chewing tobacco?

Medical health history

Do you have or have you had any of the following? (check all that apply)

- ☐ Heart problems
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur
- ☐ Heart valve problem
- ☐ Taking heart medication
- ☐ Rheumatic fever
- ☐ *Pacemaker*
- ☐ Artificial heart valve
- ☐ Blood problems
- ☐ Easy bruising
- ☐ Frequent nosebleed/abnormal bleeding
- ☐ Blood disease
- ☐ Anemia
- ☐ Ever require a blood transfusion?
- ☐ Allergy problems
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Taking allergy medication
- ☐ Asthma
- ☐ Intestinal problems
- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Special diet
- ☐ Constipation/diarrhea
- ☐ Kidney or bladder problems
- ☐ Fainting spells, seizures or epilepsy
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Pre-medications required by physician
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Urinate more than six times a day
- ☐ Thirsty or mouth is dry much of the time
- ☐ Family history of diabetes
- ☐ Tuberculosis or other respiratory disease
- ☐ Bone or joint problems
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement (e.g. hip, pins, implants)
- ☐ Do you drink alcohol?
  If so, how much? _____
- ☐ Hepatitis, jaundice or liver trouble
- ☐ Herpes or other STD
- ☐ HIV positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?
- ☐ Head injury
- ☐ Epilepsy or other neurologic disease
- ☐ History of alcohol or drug abuse

During the past 12 months, have you taken any of the following?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g. Coumadin)
- ☐ High blood pressure medicine
- ☐ Tranquilizers
- ☐ Insulin, Tolbutamide or similar drug
- ☐ Aspirin
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Natural remedies
- ☐ Nonprescription drug/supplements
- ☐ Other: _____

Are you allergic or have you reacted adversely to any of the following?

- ☐ Local anesthetics (Novocain)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin, acetaminophen or ibuprofen
- ☐ Codeine, Demerol or other narcotics
- ☐ Metals
- ☐ Latex or rubber dam
- ☐ Other: _____
- ☐ What medications are you currently taking?
  taking? _____
  _____
  _____

Women

- ☐ Are you taking contraceptives or other hormones?
- ☐ Are you pregnant?
- ☐ If so, expected delivery date_____
- ☐ Have you reached menopause?
- ☐ If so, do you have symptoms?

_____ _____

Patient signature/legally authorized representative | Date

_____ _____

Printed name if signed on behalf of the patient | Relationship

_____ _____

Doctor signature | Date

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