SHELLY MCAVOY, D.M.D.

COOPER CREEK DENTAL

Where you're more than a patient

ANN MOONEY, D.M.D.

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DENTAL HISTORY

Name ______________________ Date of Birth ______________

WHEN WAS YOUR LAST: Dental Exam? ______________ Cleaning? ______________

Dental X-Rays? ______________ Oral Cancer Screening? ______________

Why did you leave your previous dentist? ______________________

Name of Previous Dentist ______________ City ______________ State ______

SENSITIVITY/DISCOMFORT OF YOUR TEETH:

Are you having any PAIN/DISCOMFORT? ______________

Where? UR LR UL LL

Rate your current pain from 1 - 10, with 10 being most painful:

1 2 3 4 5 6 7 8 9 10

	Yes	No
Do you have CHIPPED, BROKEN, OR CRACKED Teeth?	☐	☐
Do you have any SENSITIVITY to:		
HOT?	☐	☐
COLD?	☐	☐
SWEETS?	☐	☐
Are you anxious/nervous upon coming to the dentist office?	☐	☐
Do you use Sensitive Toothpaste?	☐	☐
Do you use Home Fluoride?	☐	☐
Does your mouth get DRY?	☐	☐

HOME CARE:

Do you use an Electric Toothbrush? ☐ ☐

What Brand? ______________

Do you use a manual toothbrush? ☐ ☐

Do you use soft, medium, or hard bristles? ______

How often do you brush? ______ times per day

How often do you floss? ______ times per day

Are you concerned about bad breath? ☐ ☐

HABITS:

Do you smoke or use chewing tobacco? ☐ ☐

How much? ______ For how long? ______

Do you drink? ☐ ☐

How much? ______ # of drinks per week ______

	Yes	No
CONTACT/NON-CONTACT SPORTS:		
Are you involved?	☐	☐
List sport(s) ______________		
Have you ever worn a mouthguard or Athletic guard?	☐	☐
Have you ever worn Sports Enhancement appliances?	☐	☐
TMJ:		
Do you have Headaches, Earaches, or Neck Pain?	☐	☐
Do you have Jaw Joint/TMJ Paint?	☐	☐
Do you Grind or Clench your teeth?	☐	☐
Have you ever had Orthodontic Treatment?	☐	☐
If yes, do you have an Orthodontic Retainer?	☐	☐
Do you have a Night Guard?	☐	☐
How often do you wear it? ______________		
PROSTHODONTICS:		
Do you have or have you had any of the following?		
Removable Dentures?	☐	☐
Removable Partial Dentures?	☐	☐
PERIODONTAL HISTORY:		
Do you have Bleeding, Swollen, or Irritated gums?	☐	☐
Do you have Loose, Tipped, or Shifting teeth?	☐	☐
Have you ever had Periodontal (gum) treatments?	☐	☐
Have you ever had Periodontal/Deep Cleanings?	☐	☐
ESTHETICS:		
If you could easily whiten your teeth, would you do it?	☐	☐

If I could change my smile, I would: (check all that apply)

- Make them Whiter ______
- Make them Straighter ______
- Close Spaces ______
- Replace black metal fillings with Tooth Colored Restorations ______
- Repair chipped teeth ______
- Replace missing teeth ______
- Replace old crowns that don't match ______
- Have a Smile Makeover ______

ON A SCALE FROM 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

How would you rate your dental health now?

1 2 3 4 5 6 7 8 9 10

Where you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental work? ______________

What is the most important thing to you about your dental visit today? ______________

What can we do to make your visit more comfortable? ______________

Patient Signature ______________________ Date ______________

MEDICAL HISTORY

Name ______________________ Date of Birth ______________

Physician's Name ______________________ Physician's Phone # ______________

Have you ever needed to take antibiotics prior to dental work? Yes ______ No ______ Why? ______________

Do you take antibiotics now prior to dental work What? ______________________

Do you have or have you ever had the following:

	Yes	No
CARDIOLOGY:		
Angina/Chest Pain?	☐	☐
Heart Lesions or Abnormalities?	☐	☐
Please explain ______________		
Do you have Heart Murmur?	☐	☐
Was it detected at birth?	☐	☐
High Blood Pressure?	☐	☐
Low Blood Pressure?	☐	☐
Defibrillator or Pacemaker? When ______	☐	☐
Stroke?	☐	☐
Heart Surgery	☐	☐
If yes, when? ______ Type? ______		
Do you take Coumadin, Warafin, Plavix? INR?	☐	☐
Do you take a baby Aspirin daily?	☐	☐
Other Heart Conditions?	☐	☐
Please explain ______________		
Name of Cardiologist ______________		
Phone # ______________		
BLOOD DISORDERS:		
Anemia?	☐	☐
Do you bruise easily?	☐	☐
Excessive bleeding?	☐	☐
Other types of Blood Disorders?	☐	☐
If yes, please describe ______________		
CANCER:		
Human Papilloma Virus (HPV)?	☐	☐
Head, Neck or Oral Cancer?	☐	☐
Other types of Cancer? Please list below	☐	☐
______________		
Was it removed by Surgery?	☐	☐
Have you had Chemotherapy?	☐	☐
When? ______________		
Have you ever had Radiation Therapy?	☐	☐
When? ______________		
LIVER DISEASE:		
Hepatitis? Type? ______	☐	☐
Other Liver Disorders? ______	☐	☐
WOMEN ONLY:		
Are you Pregnant?	☐	☐
What Trimester are you in? ______		
Are you breast feeding?	☐	☐
Do you take Birth Control Pills?	☐	☐

	Yes	No
NEUROLOGY/PSYCHOLOGY:		
Alzheimer's?	☐	☐
Seizures?	☐	☐
Fainting?	☐	☐
Nervousness?	☐	☐
Depression?	☐	☐
Anxiety?	☐	☐
Other? ______	☐	☐
RESPIRATORY:		
Allergies?	☐	☐
Asthma?	☐	☐
Emphysema or COPD?	☐	☐
Other? ______	☐	☐
MISCELLANEOUS:		
AIDS or HIV?	☐	☐
Arthritis?	☐	☐
Type? ______		
Artificial Joints?	☐	☐
When? ______ Type? ______		
Diabetes?	☐	☐
Alcohol Addiction?	☐	☐
Drug Addiction?	☐	☐
Tuberculosis?	☐	☐
Gastric Reflux?	☐	☐
Thyroid Disease?	☐	☐
Are you taking any medications for osteoporosis (bisphosphonates)?	☐	☐
What? ______		
How long are/were you taking it? ______		
Do you have any other disease, problem or condition not listed above?	☐	☐
Please explain ______		
Allergy to Latex?	☐	☐

ALLERGIES TO MEDICATIONS:
(i.e. Rash, Itching/Swelling)

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PLEASE LIST ALL MEDICATIONS THAT YOU TAKE AND REASON YOU TAKE THEM:

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AUTHORIZATION AND RELEASE

I understand that this information will be held in the strictest confidence and it is my responsibility to inform Cooper Creek Dental of any changes in my medical status. I acknowledge that this information is true and I understand not being forthcoming with information may impede, hinder, or contraindicate my dental treatment and I will not hold the dentist liable for my misrepresentation of information. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. Upon diagnosis, I authorize the dentist to give me all treatment options so I can make an informed decision. I authorize the dentist to perform the needed treatment and administer or prescribe any necessary medication.

Patient/Guardian Signature ______________________ Date ______________

Dental Signature ______________________ Date ______________