Thank you for choosing
Antigo Complete Dental Center

How did you hear about us? ____

Dental History:

Reason for today's visit ________________ Date of last dental visit____________________________

Please check one or the other below:

_____ I am interested in this emergency appointment only

_____ I am interested in additional dental services after today's appointment (please circle all that apply)

Bad breath	Bleeding gums	Cavities/Fillings	Broken fillings
Cleanings	Periodontal treatment	Dentures/Partials	Braces
Loose teeth	Food collection between teeth	Tooth sensitivity	Bleaching
Other:	Appearance	Better function	Implants

Patient Information:

Name ____ SS#_________ - _______ -_________

If minor, child's parent or guardian name ____

Address _______________________________City _____________________ State _____ Zip_________

Birth Date_________________________________ Phone Number ______________________________

Circle One: Male or Female Work Number ______________________________

E-mail Address ______________________________ Cell Number_________________________________

Medical History:

ALLERGIES____

Current Medications ____

____

Are you taking Aspirin, Baby Aspirin, Excedrin products or Blood Thinners? Yes or No

If yes, explain____

Have you ever been told by a medical doctor that you need antibiotics before ALL dental visits? YES or NO

Are you now or have you ever taken Osteoporosis or Bone Density medications? YES or NO

Have you had any serious illnesses or operations? Yes or No If yes, describe ______________________

Do you have a history of or currently have cardiac transplant, cardiac prosthetic valve or bacterial endocarditis? Yes or No If yes, describe ____

Do you currently have any bacterial infection you are being treated for? Yes or No

If yes, describe ____

(Women) Are you pregnant? Yes or No Nursing? Yes or No Taking birth control pills? Yes or No

Circle if you have or have had any of the following:

Anemia	Arthritis	Artificial Joints	Asthma
Blood Disease/Leukemia	Cancer	Chemical Dependency	Chemo
Circulatory Problems	Cortisone Treatments	Diabetes	Date
Epilepsy	Fainting	Glaucoma	Headaches
Heart Problems	Hemophilia	Hepatitis	High Blood Pressure
HIV/AIDS	Jaw Pain	Kidney Disease	Liver Disease
Low Blood Pressure	Osteoporosis	Pacemaker	Radiation Treatment
Respiratory Disease	Shortness of Breath	Stroke	Thyroid Problems
Tobacco Habit	Tonsillitis	Tuberculosis	

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Are you experiencing any of the following? (please check any of the boxes below that apply to you)

- ❑ Sensitivity (hot, cold, sweet)
- ❑ Clicking or popping in the jaw
- ❑ Pain or discomfort
- ❑ Head, neck or jaw pain (or injuries)
- ❑ Clenching or grinding of your teeth
- ❑ Sores or lumps near your throat or mouth
- ❑ Bad breath or bad taste in your mouth

Do you have or have you had any of the following? (please check any of the boxes below that apply to you)

- ❑ Ortho treatments, such as braces or a retainer
- ❑ Dentures or partial dentures
- ❑ Periodontal (gum) treatments

If you could whiten your teeth for a cost anyone could afford, would you do it? ❑ Yes ❑ No

Do you smoke or use chewing tobacco? ❑ Yes ❑ No If yes, how much and for how long?

If you could adjust your smile, what would you want? (please check any of the boxes below that apply to you)

- ❑ Brighter/whiter teeth
- ❑ Straighter teeth
- ❑ Close spaces
- ❑ Replace metal fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth or old crowns

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

How important is your oral health to you? (circle one) 1 2 3 4 5 6 7 8 9 10

How would you rate the status of your oral health? (circle one) 1 2 3 4 5 6 7 8 9 10

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

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

PATIENT SLEEP HISTORY

Please check the box if you currently have or have ever had any of the following conditions or behaviors:

- ❑ Feeling tired or sluggish during the day
- ❑ Snoring (or being told you snore)
- ❑ Difficulty breathing while you sleep
- ❑ Frequent naps during the day
- ❑ Using or ever have used a CPAP

EMERGENCY AND PHYSICIAN CONTACT INFORMATION

Name of Emergency Contact	Relationship to Patient	Contact Phone Number ( )
Name Primary Physician	Physician Office Location	Physician Phone Number ( )
Name of Preferred Pharmacy	Location	Phone Number ( )
Name of Specialty Doctor	Physician Office Location	Physician Phone Number ( )