

# American Dental Service Initial Clinical Review

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
 Telephone \_\_\_\_\_ Cellphone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Social Security Number \_\_\_\_\_  
 Female or Male (Please Circle)  
 Do you have dental insurance? Y or N  
 If so, who is your insurance company?  
 \_\_\_\_\_

Who is the subscriber/cardholder \_\_\_\_\_  
 What is their Social or Policy Id # \_\_\_\_\_  
 Date of last full mouth X-rays \_\_\_\_\_  
 Date of last dental visit \_\_\_\_\_  
 Date of last dental cleaning \_\_\_\_\_

1. Do you have any areas in your mouth that concern you now? Y or N  
 If so, where? \_\_\_\_\_  
 2. What are your teeth sensitive to:  
 Hot Y or N  
 Sweets Y or N  
 Cold Y or N  
 Pressure Y or N  
 3. Have you ever heard of periodontal disease( You might have heard it called Pyorrhoea or Gum disease)? Y or N  
 What do you know about it? \_\_\_\_\_

4. Have you ever been examined for it? Y or N  
 5. Have you experienced:  
 Clicking of jaw? Y or N  
 Pain (joint, ear, side of your face)? Y or N  
 6. When there is something to be done, do you tend to wait until a problem arises, or do you prefer to handle it before there is a crisis?  
 ( ) Necessity ( ) Possibility  
 7. Do you believe in preventive dentistry? Y or N  
 8. Do you or have you been told that you?  
 Clench or grind your teeth? Y or N  
 Bite your lips/cheeks? Y or N  
 Hold foreign objects with your teeth? Y or N  
 9. Breathe through your mouth while awake or asleep? Y or N

Place of Employment \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Can you receive calls at work regarding your Appointments? Y or N  
 Physician's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Closest living relative \_\_\_\_\_  
 Telephone \_\_\_\_\_

Please circle the office in which you are being seen today  
 Exeter Wyomissing Kenhorst  
 Ortho Phoenixville Muhlenberg  
 Pottstown Gilbertsville  
 Hamburg Sinking Spring

10. Are there any changes you would like to make to your teeth? Y or N  
 \_\_\_\_\_  
 11. Are you satisfied with the color of your teeth?  
 \_\_\_\_\_  
 12. What is most important to you in a dentist? Y or N  
 \_\_\_\_\_  
 13. What are your expectations of this office?  
 \_\_\_\_\_  
 14. What did you like most about your previous dentist?  
 \_\_\_\_\_  
 15. What did you like least? \_\_\_\_\_  
 16. Why did you leave your previous dentist?  
 \_\_\_\_\_  
 17. How long do you want to keep your teeth?  
 \_\_\_\_\_  
 18. Are you interested in cosmetic dentistry?  
 Veneers?  
 Bleaching? Y or N  
 Straightening? Y or N  
 19. If we find something that needs to be done to your mouth, do you want all the details about it or do you want an overview?  
 ( ) Detailed  
 20. Where did you hear about us? ( ) Overview  
 Newspaper \_\_\_\_\_  
 Magazine \_\_\_\_\_ Restaurant Placemats \_\_\_\_\_  
 Family Member \_\_\_\_\_ Bus Stop Advertisements \_\_\_\_\_  
 Bill Board \_\_\_\_\_ Friend \_\_\_\_\_  
 Other \_\_\_\_\_  
 If so, what? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# American Dental Service Health History

Name \_\_\_\_\_

Date \_\_\_\_\_

**Answer All Questions By Circling (Y) or (N)**

1. Are you in good health? Y or N  
If no, explain \_\_\_\_\_
2. Has there been any change in your general health in the past year? Y or N
3. Date of last physical medical exam \_\_\_\_\_
4. Are you now under a physician's care for a particular problem? Y or N  
If so, for what? \_\_\_\_\_
5. Have you ever had any serious illnesses, operations or hospitalizations? Y or N  
If so, describe \_\_\_\_\_
6. Do you have or have you ever had:
  - A. Rheumatic fever or rheumatic heart disease? Y or N
  - B. Congenital heart disease? Y or N
  - C. Cardiovascular disease (Heart attack, Heart trouble, Heart murmur, High blood pressure, Stroke, Palpitations, Heart surgery, Pacemaker, Coronary artery disease, Mitral valve prolapse, Angina)? Y or N
  - D. Lung disease (Asthma, Emphysema, Chronic cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of breath, Lung prolapsed, Chest pain)? Y or N
  - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y or N
  - F. Bleeding disorder, Anemia, Bleeding tendency, Blood transfusion? Do you bruise easily? Y or N
  - G. Liver disease (Jaundice, Hepatitis)? Y or N
  - H. Kidney disease? (Dialysis) Y or N
  - I. Diabetes Y or N
  - J. Thyroid disease or Goiter? Y or N
  - K. Arthritis? Y or N
  - L. Stomach Ulcer or Colitis? Y or N
  - M. Glaucoma? Y or N
  - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?
  - O. Radiation (X-ray) treatment for Cancer? Y or N
  - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth grinding or clenching of the teeth? Y or N
  - Q. Sinus or nasal problems? Y or N
8. Are you using any of the following:
  - A. Antibiotics? Y or N
  - B. Anticoagulants (blood thinners)? Y or N
  - C. Aspirin or drugs such as Motrin, Aleve? Y or N
  - D. High blood pressure medications? Y or N
  - E. Steroids (cortisone, etc.)? Y or N
9. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals \_\_\_\_\_

**All Responses Are Kept Confidential**

10. Any disease (such as AIDS), drugs, or transplant operation that has suppressed your immune system? Y or N
11. Do you wish to talk to the doctor privately about anything? Y or N
12. Are you allergic to or had an adverse reaction to:
  - A. Local Anesthesia (Novocain, etc.)? Y or N
  - B. Penicillin or other antibiotics? Y or N
  - C. Sedatives, Barbiturates? Y or N
  - D. Aspirin or Ibuprofen? Y or N
  - E. Codeine or other pain killers? Y or N
  - F. Latex or other rubber products? Y or N
  - G. Other allergies or reactions? Y or N
 Please list \_\_\_\_\_
13. Have you or immediate family member had any problem associated with intravenous anesthesia? Y or N
14. Do you smoke or chew tobacco? Y or N  
How much per day? \_\_\_\_\_
15. Is there any current or past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you with? Y or N
16. Have you had any serious problems related to any previous dental treatment? Y or N  
If yes, specifically what? \_\_\_\_\_
17. Do you have any other disease, condition, or problem not listed above that you think the doctors should know about? Y or N
18. Do you have or have you ever been told to pre medicate prior to any dental procedure? Y or N
19. Have you experienced the following:
  - Extraction/Oral surgery? Y or N
  - Periodontal(gum) disease or surgery? Y or N
  - Orthodontic treatment? Y or N
  - Dental Implant? Y or N
  - Temporomandibular disorder? Y or N
  - Root canal treatment? Y or N
  - An injury to a tooth or jaw? Y or N
  - Has your bite been adjusted? Y or N
20. For Woman Only:
  - A. Are you pregnant, or is there any chance you might be? Y or N
  - B. Are you nursing? Y or N
  - C. If you are using oral contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or the other medication is completed. Please consult with your physician for further guidance.

