Darling Dental

**Patient Information**

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email address: _____ How would you like to be contacted? _____

Marital Status: ▫ Minor ▫ Single ▫ Married ▫ Divorced ▫ Widowed ▫ Separated

Patient's Employer: _____

Spouse or Parent/Guardian's Name: _____

Employer:_____ Work Phone: _____

Person to contact in case of emergency: _____

Relationship: _____Phone #_____

***Dental Insurance***: Yes or No

Insurance Company:_____ Policy holder name: _____

Insurance/member ID# : _____ Policy holder DOB: _____

Insurance Company's phone number: _____

***Responsible Party (the person who will pay the bill):***

Name of person responsible for this account: _____

Relationship to patient: _____

Address:_____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Birthdate: _____

Employer: _____

Is this person currently a patient in our office? Yes No

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Payment is expected at each appointment. For your convenience, we offer the follow methods of payment.

**Cash, all major credit cards, Lending Club & Care Credit**

**How did you hear about our office?** Darling Dental website, friend (we'd like to thank him/her), other:

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## Medical & Dental History

**Physician Name:**

**Physician phone #:**

| | | |
|---|---|---|
| Have there been any changes to your health in the past year? Any procedures, surgeries, new diagnosis or new/changed medications? If yes, please list: | Yes | No |
| Are you currently being treated by a healthcare provider for any illness or condition? If yes, please provide details: | Yes | No |
| Have you had an orthopedic joint replacement? If yes, please list doctor's info and date of surgery: | Yes | No |
| Have you taken or are you currently taking: bisphosphonate agents for osteoporosis, Paget's disease, cancer treatments or hypercalcemia (ex: Alendronate, Fosamax, Atelvia, Boniva, Reclast, Prolia, Aredia, Zotema)? | Yes | No |
| Are you taking any medications, pills or drugs - prescription or over the counter? If yes, please list on the **CURRENT MEDICATIONS LIST**. | Yes | No |

**Are you allergic to any of the following? ___ No known allergies**

| | | |
|---|---|---|
| **ANTIBIOTICS:** | Clindamycin, Azithromycin, Penicillin, | Cephalosporin (Keflex), Amoxicillin |
| Metals (Mercury, nickel) | Latex | Codeine or other Narcotics |
| Acetaminophen | Ibuprofen | Aspirin |
| **OTHERS:** | | |
| | | |

**Do you have or have you ever had any of the following?**

| | | |
|---|---|---|
| Artificial heart valve | Yes | No |
| Damaged valves in transplanted heart | Yes | No |
| Repaired congenital heart disease with residual defects | Yes | No |
| Previous infective endocarditis | Yes | No |
| Unrepaired, cyanotic congental heart disease | Yes | No |
| CHD repaired completely in the last 6 months | Yes | No |

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## Medical & Dental History

### Do you currently have, or have you ever had, any of the following?

| Heart (Cardiac) Health | Cancer | Yes / No | Digestive Health |
|---|---|---|---|
| Pacemaker / implanted defibrillator | Type: | | Gastrointestinal disease |
| Artificial (prosthetic) heart valve | Date of diagnosis: | | GE reflux/persistant heartburn(GERD) |
| Previous infective endocarditis | Chemotherapy | | Stomach ulcers |
| Congenital heart disease (CHD) | Radiation treatment | | **Eye (Vision) Health** |
| Unprepared, cyanotic CHD | **Blood (Circulatory) Health** | | Glaucoma |
| Repaired (completely) in last 6mo | Anemia | | **Other** |
| Repaired CHD with residual defects | Blood transfusion, date: | | Arthritis, type: |
| Arteriosclerosis | Hemophilia | | Chronic pain |
| Coronary artery disease | High or low blood pressure | | Diabetes (type I or II) |
| Congestive heart failure | **Brain (Neurological) / Mental Health** | | Eating disorder |
| Damaged heart valves | Dental Anxiety | | Frequent infections |
| Heart attack | Depression | | Type of infection: |
| Heart murmur/rhythm disorder | Epilepsy | | |
| Rheumatic heart disease | Mental health disorders | | Hepatitis, jaundice or liver disease |
| Stroke | Neurological disorders | | Immune deficiency |
| **Breathing (Respiratory) Health** | Post-traumatic stress disorder | | Kidney problems |
| COPD | Traumatic brain injury or concussion | | Malnutrition |
| Asthma | **Autoimmune Disease** | | Osteoporosis |
| Tuberculosis | AIDS or HIV | | Thyroid problems |
| Emphysema | Lupus | | Sexually transmitted infection (STI) |
| Sinus trouble | Lichen Planus | | |

**Do you have any disease, condition, or problem that's not listed here? If so, please explain:**

**If Applicable:**

| | | |
|---|---|---|
| Are you pregnant? | Yes | No |
| Are you nursing? | Yes | No |
| Are you taking birth control pills? | Yes | No |

Darling Dental

**Medical & Dental History**

Name of Previous Dentist and Location_____

Date of Last Exam & Cleaning _____

| ***Do you currently have, or have you ever had, any of the following?*** | | |
|---|---|---|
| | | |
| Do your gums bleed while brushing or flossing? | Yes | No |
| Are your teeth sensitive to hot or cold liquids/foods? | Yes | No |
| Are your teeth sensitive to sweet or sour liquids/foods? | Yes | No |
| Do any of your teeth hurt? | Yes | No |
| Do you have any sores or lumps in or near your mouth? | Yes | No |
| Have you had any head, neck or jaw injuries? | Yes | No |
| Do you have frequent headaches? | Yes | No |
| Do you clench or grind your teeth? | Yes | No |
| Do you bite your lips or cheeks frequently? | Yes | No |
| Have you ever had any prolonged bleeding after dental extractions? | Yes | No |
| Have you had any orthodontic treatment? | Yes | No |
| Do you have a retainer? Yes / No Do you wear it? Yes / No Upper or lower? | | |
| Do you wear a full denture or a removable partial denture? If yes, date of fabrication: | Yes | No |
| | | |
| Have you ever received oral hygiene instructions for the care of your teeth & gums? | Yes | No |
| Do you have any chief concerns regarding your smile, teeth, or oral health? Please explain: | Yes | No |
| Have you ever experienced any of the following problems with your jaw? | Yes | No |
| Clicking Pain (joint, ear, side of face)<br>Difficulty in opening, closing or chewing Jaw locked open or closed<br>**If you have experienced any of these symptoms, please complete the attached TMJ QUESTIONAIRE.** | | |

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# TMJ QUESTIONAIRE

| | | | | | | |
|---|---|---|---|---|---|---|
| **JAW JOINT SYMPTOMS** | | | | | | |
| Do you have pain in your jaws? Right, left or both | Yes | No | | Does your jaw feel tired after a big meal? | Yes | No |
| Are you capable of chewing gum? | Yes | No | | Are there any foods you avoid eating? | Yes | No |
| Are you capable of chewing a bagel? | Yes | No | | Do you have difficulty opening wide or yawning? | Yes | No |
| Do you hear noises in your jaw joint? | Yes | No | | Do you ever get dizzy? | Yes | No |
| Has your jaw ever locked open or closed? | Yes | No | | Does your jaw ache when you open wide? | Yes | No |
| Can you make your jaw pop or crack? | Yes | No | | Do you ever feel faint? | Yes | No |
| Is there a family history of jaw joint (TMJ) problems or headaches? | Yes | No | | Do you ever feel nauseated? | Yes | No |
| **PAIN SYMPTOMS** | | | | | | |
| Do you get headaches? | Yes | No | | Do you get headaches in the right or left temple areas? | Yes | No |
| Do you get migraine headaches? | Yes | No | | Do you get headaches in the front or back of your head? | Yes | No |
| Do you frequently have neck aches or stiff neck muscles? | Yes | No | | Do you clench your teeth during the day? | Yes | No |
| Have you ever had chronic shoulder or back pain? | Yes | No | | Do you think you clench your teeth at night? | Yes | No |
| Do you have trouble sleeping soundly? | Yes | No | | Do you think you grind your teeth when asleep? | Yes | No |
| Are your jaws tired when you awaken? | Yes | No | | When are your pain symptoms the worst? | | |
| Are your teeth sore when you awaken? | Yes | No | | Does anything make you feel better? | Yes | No |
| Have your wisdom teeth been extracted? | Yes | No | | What?_____ | | |
| What medications, if any, are you taking? | | | | How often do you take medication for relief of pain? | | |
| **TRAUMA SYMPTOMS** | | | | | | |
| Have you ever had a severe blow to the head or jaw? | Yes | No | | Have you ever been involved in any serious accidents, such as a car accident? Details: | Yes | No |
| Any whiplash neck injuries? | Yes | No | | | | |
| **EAR & EYE SYMPTOMS** | | | | | | |
| Do you have pain in either ear? | Yes | No | | Do you wear glasses or contacts? | Yes | No |
| Do you suffer from any loss of hearing? | Yes | No | | Are there times when your eyesight blurs? | Yes | No |
| Do you have itchiness or stuffiness in either ear? | Yes | No | | Do you get pain in, around or behind either eye? | Yes | No |
| Do you hear ringing, buzzing, or hissing sounds in either ear? | Yes | No | | | | |
| **BREATHING** | | | | | | |
| Do you have allergies? | Yes | No | | Is your nose stuffed when you don't have a cold? | Yes | No |
| Do you have sinus problems? | Yes | No | | Have you been diagnosed with Sleep Apnea? | Yes | No |
| Do you snore at night? | Yes | No | | Have you had a sleep study done at a Sleep Clinic (hospital)? | Yes | No |

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## CURRENT MEDICATION LIST

| | Medication | Reason Taking | How Much | How Often |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

The above information is true to the best of my knowledge. I hereby grant Nathan Darling, DDS and Darling Dental LLC to administer any treatment agreed upon or to administer such anesthetics and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Darling Dental LLC to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care, to third-party payers and or health practitioners. I authorize and request my insurance company to pay directly to the Darling Dental LLC insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X**_____ **Date** _____
Signature of patient (Or parent/guardian if minor)

**X**_____
Print Name

**X**_____ **Date** _____
Signature of treating dentist (Nathan S. Darling, DDS)