Dr. Patti A. Froeber

"Dedicated To Excellence"

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Client Care Information

Name: _____ (Last / First / Middle) Sex: ❑ Male ❑ Female

Birthdate: _____ Please Check: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Separated ❑ Widowed

Home Phone: _____ Business Phone: _____ Social Security #: _____

Home Address: _____ (Street / City / State / Zip)

Employer: _____ Present Position: _____

Business Address: _____ (Street / City / State / Zip)

Name of Spouse: _____ Name of Children: _____

Spouse Employer: _____ Present Position: _____

Name of Person to Notify in an Emergency: _____

Relationship: _____ Phone: _____

Address: _____ (Street / City / State / Zip)

Previous D.D.S.: _____ Last Seen: _____

Address: _____ Phone: _____

Physician Name: _____ Last Seen: _____

Address: _____ Phone: _____

Person responsible for my account: _____

Names of other family members seen here: _____

Whom may we thank for this referral? _____

For Patients with Dental Insurance

Insured Person's Name _____ #Insured's Birthdate: _____

Insured Social Security # _____ Insurance ID: _____

Name of Insurance Plan: _____ Group# _____

Insurance Plan Address: _____

Insured Person's Name _____ #Insured's Birthdate: _____

Insured Social Security # _____ Insurance ID: _____

Name of Insurance Plan: _____ Group# _____

Insurance Plan Address: _____

Providing you comprehensive care in a calm and comforting environment is our greatest concern. It is an important part of our philosophy to understand your needs, values, and concerns. For this reason, we ask you to please share the following information about yourself.

Orientation - Dental History

1. Your approximate age at first dental appointment: _____
2. Was care regular? _____
3. Did you have a lot, average, or very little decay as a child? _____
4. What are/were your parents dental conditions and care habits? _____

   _____
5. What has your past 5 years dental care been? _____

   _____
6. Have you ever had:

   orthodontic treatment? _____

   oral surgery? _____

   your bite adjusted? _____

   root canal treatment? _____
7. Do you experience sensitivity to heat, cold or pressure? _____
8. Does food tend to get caught between your teeth? _____
9. Do you brush your teeth vigorously, moderately or lightly? _____
10 How often do you brush your teeth? _____
11. How often do you floss your teeth? _____
12. Have you ever had professional instructions in home care? _____
13. Habits: Do you...

   clench your teeth during the day? _____

   clench your teeth at night? _____

   bite your lips or cheeks regularly? _____

   have you been told you snore? _____

   have you been told you stop breathing while sleeping? _____

   do you have excessive daytime sleepiness? _____

   use tobacco or smoke? _____

   consume alcohol daily? _____
14. Problems of the jaw: Have you ever experienced...

   clicking of the jaw? _____

   pain (joint, ear, side of face)? _____

   difficulty in chewing? _____

   chronic neck or shoulder pain? _____

   chronic headaches? _____

Orientation - Dental History

15. Have you noticed any loosening of your teeth? _____
16. Do you suffer from pain and/or swelling of your gums? _____
    Any pus around the gums? _____
17. Do your gums often bleed when you floss your teeth? _____
18. Have you ever suspected you have mouth odor? _____
19. Have you ever heard of periodontal disease? _____
20. Do you have any missing teeth? _____
    How long have they been missing? _____
    Why didn't you have them replaced? _____
    Was it ever suggested? _____
21. Can sugar be found frequently in your daily diet? _____
    Is it consumed with meals? _____
    Is it consumed between meals? _____
22. Do you take a daily vitamin supplement? If so, which one? _____
23. Are the five food groups part of your meals? _____
24. How can we help you; i.e., your expectations, needs, concerns. What is important to you? What are you looking for in a dental office?
    Expectations: _____
    Needs: _____
    Concerns: _____
25. Do you think dental disease is active or controlled in your teeth and tissues? _____
26. Is your general health and dental health a value of yours? _____
27. How would you rate your present dental health? 1 2 3 4 5 6 7 8 9 10 (1 = Poor, 10 = good)
    Why? _____
28. How would you rate your present general health? 1 2 3 4 5 6 7 8 9 10 (1 = Poor, 10 = good)
    Why? _____
29. Have you ever had any particularly good or bad experiences in dentistry? _____
30. Do you have any dental anxieties? _____
31. Do you go to a dentist to be cared for, to learn to become more healthy, or both? _____
32. If you were given a magic wand and could change anything about your smile and/or dental health, what would it be? _____
    _____
    _____
33. What are your dental health goals 5 -10 years from now and for the rest of your life? _____
    _____
34. In your opinion, what prevents you from achieving your dental health goals? _____
    _____
    _____
35. Has a dental team ever helped you set up a plan so you could be successful with your goals? _____
36. How do you enjoy spending your free time? _____
    _____
    _____

Medical History

1. Do you feel you are in good health? ..... ❑ YES ❑ NO

   A. Has there been any change in your general health in the past year? ..... ❑ YES ❑ NO

   If so, explain _____

2. Your last physical was: Date: _____ Year: _____

3. Are you now under the care of a physician? ..... ❑ YES ❑ NO

4. These conditions need a pre-medication before any dental procedure. Please check any of the following that apply to you now or in the past.

   ❑ heart murmur ❑ mitro valve prolapse ❑ artificial valve ❑ rheumatic fever

   ❑ prosthetic implant (joint - hips) ❑ surgery with pins ❑ open heart surgery

5. Please check any of the following that apply to you now or in the past?

   ❑ Heart disease
   ❑ Depression
   ❑ Abnormal blood pressure
   ❑ AIDS/HIV
   ❑ Excessive urination or thirst
   ❑ Epilepsy
   ❑ Glaucoma
   ❑ Diagnosed with sleep apnea
   ❑ Hay fever
   ❑ Tuberculosis
   ❑ Diabetes
   ❑ Blood relatives with diabetes
   ❑ Anemia
   ❑ Cancer
   ❑ Transplant surgery
   ❑ Use a CPAP machine
   ❑ Nervous disorder
   ❑ Seizures
   ❑ Hepatitis A
   ❑ Hepatitis B
   ❑ Hepatitis C
   ❑ Bruise easily
   ❑ Asthma
   ❑ Radiation therapy
   ❑ Counseling
   ❑ Jaundice
   ❑ Abnormal bleeding
   ❑ Blood transfusion
   ❑ Emphysema
   ❑ Arthritis
   ❑ Fainting spells
   ❑ Venereal disease
   ❑ Pacemaker
   ❑ Ulcers
   ❑ Kidney trouble
   ❑ Tumor
   ❑ Other_____

6. Please check if you are taking any of the following medications?

   ❑ Antibiotics or sulfa drugs
   ❑ Anticoagulants (blood thinners)
   ❑ Medication for high blood pressure
   ❑ Steroids
   ❑ Tranquilizers
   ❑ Insulin, Tolbutamide (orinase or similar drug)
   ❑ Heart medications
   ❑ Nitroglycerin
   ❑ Antihistamine
   ❑ Birth Control Pill
   ❑ MAO Inhibitors (i.e. Marplan, Nardil, Parnar)
   ❑ Antidepressants (i.e. Prozac, Lithium, Tegrel)
   ❑ Other_____
   ❑ _____
   ❑ _____
   ❑ _____
   ❑ _____
   ❑ _____

7. Please check if you are allergic to any of the following?

   ❑ Local anesthetics
   ❑ Penicillin or other antibiotics
   ❑ Iodine, seafood
   ❑ Sulfa drugs
   ❑ Aspirin
   ❑ Barbiturates, sedatives or sleeping pills
   ❑ Codeine, other narcotics
   ❑ Latex sensitivity
   ❑ Bi-Sulfites
   ❑ Other_____
   ❑ Other_____
   ❑ Other_____

8. (Women) Are you pregnant? ❑ YES Due date: _____ ❑ NO

9. Have you had serious trouble associated with previous dental treatment? If so, explain _____

_____

_____

Signature: _____ Date: _____

Medical Update: Note changes, date and sign

Date: ❑ No Change B.P. Notes	Date: ❑ No Change B.P. Notes	Date: ❑ No Change B.P. Notes
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