# Le'Centre Dentistry

312 Central Avenue S.E., Suite 440 • Minneapolis, MN 55414 • (612) 379-2428 • www.lecentredentistry.com

## Client Care Information

Name: ______________________________ Sex: ❑ Male ❑ Female ❑ ________
Last First Middle

Email: ______________________ Social Security #: ______________________

Birthdate: __________ Cell Phone: __________ Home Phone: __________

Home Address: ______________________________

Employer: ______________________ Present Position: ______________________
Street City State Zip

Name of Spouse: ______________________ Name of Children: ______________________

Name of Person to Notify in an Emergency: ______________________

Relationship: ______________________ Phone: ______________________

Previous Dentist: ______________________ Date of last Dental Cleaning: __________

Person responsible for my account: ______________________

Names of other family members seen here: ______________________

How did you hear about our practice? ______________________

## Medical History

1. 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 may need a pre-medication before any dental procedure. Please check any of the following that apply to you now or in the past.
   ❑ mitro valve prolapse ❑ artificial valve ❑ prosthetic implant (joint - hips) ❑ open heart surgery
5. Please check any of the following that apply to you now or in the past?
   ❑ Heart disease ❑ Hay fever ❑ Anxiety ❑ Radiation therapy ❑ Fainting spells
   ❑ Depression ❑ Tuberculosis ❑ Seizures ❑ Abnormal blood pressure ❑ Diabetes
   ❑ Hepatitis A ❑ Pacemaker ❑ AIDS/HIV ❑ Blood relatives with diabetes ❑ Hepatitis B
   ❑ Abnormal bleeding ❑ Ulcers ❑ Excessive urination or thirst ❑ Anemia
   ❑ Hepatitis C ❑ Blood transfusion ❑ Kidney trouble ❑ Epilepsy ❑ Cancer
   ❑ Bruise easily ❑ Emphysema ❑ Tumor ❑ Transplant surgery ❑ Glaucoma
   ❑ Asthma ❑ Arthritis ❑ Diagnosed with sleep apnea ❑ Use a CPAP
   ❑ Other ______________________
6. Please list any over the counter or prescription medications you are on. ______________________
   ______________________
7. Please check if you are allergic to any of the following?
   ❑ Local anesthetics ❑ Sulfa drugs ❑ Codeine, or other narcotics __________
   ❑ Penicillin or other antibiotics ❑ Aspirin ❑ Latex sensitivity ❑ Iodine, seafood
   ❑ Barbiturates, sedatives ❑ Bi-Sulfites or sleeping pills ❑ Other __________
8. (Women) Are you pregnant? ❑ YES Due date: __________

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

________________________________________

________________________________________

10. 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: ______________________

11. How would you rate your present dental health? 1 2 3 4 5 6 7 8 9 10 (1 = Poor, 10 = good)

Why? ______________________

12. How would you rate your present general health? 1 2 3 4 5 6 7 8 9 10 (1 = Poor, 10 = good)

Why? ______________________

13. Do you have any dental anxieties? ______________________

14. How do you enjoy spending your free time? ______________________

________________________________________

## Orientation - Dental History

1. Have you ever had:

   orthodontic treatment? ______________________

   oral surgery? ______________________

   bite adjusted? ______________________

   root canal treatment? ______________________

2. Do you experience sensitivity to heat, cold or pressure? ***Y / N***

3. Does food tend to get caught between your teeth? ***Y / N***

4. Do you brush your teeth vigorously, moderately or lightly? ______________________

5. How often do you brush your teeth? ______________________

6. How often do you floss your teeth? ______________________

7. Do you use a power tooth brush? If so, what brand? ______________________

8. Habits: Do you...

   Clench your teeth during the day? ***Y / N*** Clench your teeth at night? ***Y / N*** Bite your lips or cheeks regularly? ***Y / N***

   Have you been told you snore? ***Y / N*** Stop breathing while sleeping? ***Y / N*** Consume alcohol daily? ***Y / N***

   Have excessive daytime sleepiness? ***Y / N*** Use tobacco,smoke or vape? ***Y / N***

9.. Problems of the jaw: Have you ever experienced...

   Clicking of the jaw? ***Y / N*** Pain (joint, ear, side of face)? ***Y / N*** Difficulty in chewing? ***Y / N*** Chronic headaches? ***Y / N***

   Chronic neck or shoulder pain? ***Y / N***

10. Do you have any of the following? ❑ Loose Teeth ❑ Painful / Swollen Gums ❑ Bleeding ❑ Bad Breath

11. Have you ever been told you have periodontal disease? ***Y / N***

Signature: ______________________ Date: ______________________

*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.*