

Kurt D. Mitchler, DDS, FAGD
Excellence in the Art and Science of Dentistry

Getting Acquainted

Patient's Name _____ Birthdate _____

Residence _____ Phone _____

City/State/Zip _____

Occupation _____ Employer _____ SSN# _____

Business Address _____ Bus. Phone _____

E-mail address _____ **Website Address** _____

Day Phone # to call for confirmation/changes in schedule _____

I prefer appointments (check one) Morning Afternoon Anytime

Former Dentist _____ Last Visit _____

Address/Phone No. _____

Personal Physician _____ Phone _____

Spouse Name _____ Birthdate/SSN# _____

Names/Ages of Children under 18 _____

In case of emergency, contact (name/relationship to patient/phone #)

Whom may we thank for referring you to this office? _____

If patient under 18, adult accompanying minor is responsible for payment:

Name (last, first, middle initial) _____

Relationship to Patient _____ Phone _____

Address/City/Zip _____

Place of Employment _____ SSN# _____

Business Address _____ Bus. Phone _____

City/State/Zip _____

I am 18 or older and understand that I am financially responsible for all charges.

RP Signature and Date: _____

Medical History

Yes	No	Check (Y/N) Nos. 1-26. Please complete "Smile Evaluation" section. All information is confidential.	
___	___	1. Have you been hospitalized for a serious illness or surgical procedure? _____	
___	___	2. Have you been under a physician's care? If yes, please explain: _____	
___	___	3. Are you now taking any medication (drugs or pills)? List: _____	
___	___	4. Do you smoke? Or use smokeless tobacco? ___Y___N	
___	___	5. Have you had any of the following?	
___	___	Heart Disease	___ ___ Psychiatric Treatment
___	___	Heart Attack	___ ___ Fainting/Dizzy Spells
___	___	High Blood Pressure	___ ___ Emphysema
___	___	Angina Pectoris	___ ___ Asthma
___	___	Heart Surgery	___ ___ Diabetes
___	___	Heart Pacemaker	___ ___ Thyroid Disease
___	___	Artificial Heart Valve	___ ___ Arthritis
___	___	Heart Defect or Murmur	___ ___ Glaucoma
___	___	Artificial Joints	___ ___ Liver Disease
___	___	Persistent Cough	___ ___ Yellow Jaundice
___	___	Allergies or Hives	___ ___ Epilepsy or Seizures
___	___	Abnormal Bleeding	___ ___ Hep A (Infectious)
___	___	Ulcers	___ ___ Hep B (Serum)
___	___	Kidney trouble	___ ___ Hep C
___	___	Sinus trouble	___ ___ HIV Positive
___	___	Cold Sores	___ ___ AIDS
___	___	Fever Blisters	___ ___ Venereal Disease
___	___	Hay Fever	___ ___ Drug Addiction
___	___	Anemia	___ ___ IV Drug Use
___	___	Blood Disease	___ ___ Alcoholism
___	___	Blood Transfusion	___ ___ Tuberculosis
___	___	Nervousness or Anxiety	___ ___ Radiation/Chemotherapy
___	___	FenPhen/Redux Diet Pill	___ ___ Rheumatic Fever
___	___	Eating Disorders	___ ___ Scarlet Fever
___	___	6. Do you have any disease, condition or problem not listed above that you think Dr. Mitchler should know about? _____	
Women:	___	7. Are you pregnant? ___Y___N; Nursing? ___Y___N; Taking birth control pills? ___Y___N	

Medicament Inquiry

___	___	8. Are you allergic (or react adversely) to any of the following?		
___	___	Aspirin	Local Anesthetic	Tetracycline
___	___	Codeine	Penicillin	Sulfa
___	___	Nitrous Oxide	Erythromycin	Latex or Rubber materials
___	___	9. Are you allergic to any other medication or substance? If yes, please list: _____		

Name _____

Dental and Periodontal History

Yes	No	
___	___	10. Are you having pain or discomfort at this time?
___	___	11. Do you feel very nervous about having dental treatment?
___	___	12. Have you ever had a bad experience in a dental office? Please describe _____
___	___	13. What did you like about your previous dental office? _____
___	___	14. Did you go to the dentist on a regular basis? Every _____ months or _____ year
___	___	15. Do your gums bleed when you brush or floss your teeth?
___	___	16. Do you have any loose teeth? Do you know why they're loose _____ yes _____ no
___	___	17. Does it appear to you that your gums are receding (pulling away from your teeth)?
___	___	18. Have you ever experienced an unusual odor coming from you mouth?
___	___	19. Do your gums appear red or puffy?
___	___	20. Are you experiencing sensitivity to hot or cold foods or beverages?
___	___	21. Do you have any missing teeth?
___	___	22. Do you have any fixed crowns or bridges in your mouth? How many? _____ crowns _____ bridges
___	___	23. Do you wear a full or partial denture? _____ top _____ bottom
___	___	24. Do you ever experience pain in your jaw muscle?
___	___	25. Do you clench or grind your teeth?
___	___	26. Do you own an bite guard? Do you wear it _____ daily _____ occasionally

Smile Evaluation

For most people, an appealing smile is an important part of the overall impression a person makes to the world. Although a vast number of adults understand the importance of a good smile, only half think their smile "makes the grade." Does YOUR smile say it all?

On a scale of 1 to 10, how would you rate your smile (10=spectacular, 1=not pleasing)? _____

If there were anything that you could change about your smile, what would that be?

How would you like your teeth and gums to look and feel for the rest of your life?

How do you feel about the color of your teeth? Please explain.

Authorization and Consent

I authorize and give consent to Dr. Mitchler to perform any dental treatment we agreed to be necessary or advisable, including the use of local anesthesia or other medication. If patient is a minor, parent or guardian must sign.

Signature _____ Date _____
(Parent or guardian if patient under 18 years)

Medical and Dental History Reviewed _____ / _____ / _____