Gole Dental Group
121 W Woodlawn Ave
Hastings Michigan 49058
(269) 948-2244

Patients Name: _____

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No If yes, then please describe: _____

Previous Dentist's Name _____ City, State _____

Why did you leave your last Dentist? _____

Who referred you to our practice? _____

When was your Last dental visit? _____ **Last cleaning**? _____ **X-rays**? _____

How often do you do the following:

Brush? _____ Floss? _____ Use a Mouth rinse? _____ What Mouth rinse? _____

What kind of Toothbrush do you use? Manual Electric Both

Please circle other dental aids used: Flosser Toothpick Waterpik Tongue scraper Bridge Aid Other_____

Are your teeth sensitive to:

Hot Cold Sweets Biting Chewing? (please circle which)	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you get cold sores, blisters, or any other oral lesions?	Yes	No
Do your gums bleed or hurt while brushing or flossing?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to get caught between your teeth?	Yes	No
If yes, then where? _____		

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
A bite splint or mouth guard?	Yes	No
A serious head or mouth injury?	Yes	No
If yes, please describe_____		
_____		
Do you have a partial, denture or dental implants?	Yes	No

Do you experience the following:

Clench or grind your teeth (while awake or asleep) ?	Yes	No
Dry mouth?	Yes	No
Hold objects with your teeth (ex: fingernails, pencils, etc.)?	Yes	No
Do you now (or in the past) use tobacco (smoke or chew)?	Yes	No
Snore or have any other sleeping disorder (ex: sleep apnea, use a CPAP)?	Yes	No

Have you experienced any of the following:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty opening or closing the mouth?	Yes	No
Difficulty chewing on either side?	Yes	No
Headaches, neck aches, backaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Please circle the following you have or do:

Cheek/Lip biting	Nail biting	Tongue thrust
Thumb sucking	Prolonged pacifier	Excessive alcohol
Drug abuse	Mouth breather	Gum chewer
Frequent Pop 3+/wk	Juice	Coffee
Tea	Sports drinks	Energy drinks
Sugared sweets	Frequent snacking	Beer
Wine	Liquor	Other not listed

How do you feel about your smile? _____

_____

Would you like to keep all of your teeth? Yes No

If yes, then are you concerned about finances to restore your teeth? Yes No

Do you feel nervous about dental treatment? Yes No

If yes, what is your biggest concern? _____

Is there anything else about dental treatment that you would like us to know? _____

Patient Name:_____

Are you currently under the care of a Physician, Specialist, Chiropractor, or Other due to a specific reason? Yes No
If yes, then please explain which and why_____

Physician, Specialist, Chiropractor, or Other's Name _____**Phone #** ( )_____

Name _____**Phone #** ( )_____

Have you been hospitalized within the last 5 years due to a Surgery, Accident, Illness, or other Condition? Yes No
If yes, then please explain _____

Are you currently taking any Vitamins, Herbal supplements, or any Medication? (Include all Prescription, Over the counter, Aspirin) Yes No
If yes, then please list names and dosages:

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

Do you have any drug allergies (or adverse reaction) that you are aware of? Yes No

(Please circle all) Penicillin Amoxicillin Clindamycin Keflex Codeine Sulfa Bactrim Other

Have you ever taken prescription medications for weight loss (diet pills)? Yes No
If yes, then please circle Fen-Phen Pondimen Redux Other
If yes, then did you have a medical exam for heart issues? Yes No

Have you ever taken bone loss prevention drugs, such as Fosamax, Actonel, Boniva, or other similar drugs? Yes No

Please circle "Yes" or "No" to each item that you have had, or have at present.

AIDS/HIV Positive	Yes No	Fainting	Yes No	Mitral Valve Prolapse	Yes No
Allergies	Yes No	Fibromyalgia/Chronic Fatigue	Yes No	Nervous Disorders	Yes No
Arthritis/Rheumatism	Yes No	Food Allergies	Yes No	Neurological Disorders	Yes No
Artificial Heart Valve	Yes No	Glaucoma	Yes No	Pacemaker	Yes No
Artificial Joints (hip,knee,etc)	Yes No	Hay Fever	Yes No	Pregnancy	Yes No
Asthma	Yes No	Head Injuries	Yes No	Pre Med	Yes No
Blood Transfusion	Yes No	Headaches / Migraines	Yes No	Prosthetics	Yes No
Bruises Easily	Yes No	Heart Attack	Yes No	Psychological/Psychiatric Care	Yes No
Cancer	Yes No	Heart Disease	Yes No	Radiation Treatment	Yes No
Chemotherapy	Yes No	Heart Murmur	Yes No	Respiratory Problems	Yes No
Chest Pain	Yes No	Heart Surgery	Yes No	Restless Leg Syndrome	Yes No
Chronic Cough	Yes No	Hepatitis A B C (circle)	Yes No	Rheumatic Fever	Yes No
Congenital Heart Disease	Yes No	High Blood Pressure	Yes No	Sinus Problems	Yes No
Cortisone Medicine	Yes No	Hives	Yes No	STD(s)	Yes No
Coumadin/Warfarin	Yes No	Jaundice	Yes No	Stent(s)	Yes No
Diabetes (Type I II circle)	Yes No	Jaw Clicking	Yes No	Stroke	Yes No
Dizziness	Yes No	Kidney Disease	Yes No	Swollen Ankles	Yes No
Ear / Eye Problems	Yes No	Latex Sensitivity	Yes No	Thyroid Problems	Yes No
Emphysema	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Epilepsy / Seizures	Yes No	Low Blood Pressure	Yes No	Tumors	Yes No
Excessive Bleeding	Yes No	Metal Sensitivities	Yes No	Ulcers	Yes No

Do you have any other disease, condition, or problem not listed? Yes No
If yes, then please list _____

Please circle if there are any of following in your family history: Cancer Stroke Heart disease Diabetes
Have you lost or gained more than 10 pounds in the last year? (please circle which one) Yes No

WOMEN ONLY: Are you pregnant or think you are pregnant? Yes No If yes, then how many months along? _____ months
Are you nursing? Yes No Do you use Birth control prescriptions? Yes No

I have answered all questions to the best of my knowledge. If further information is needed, then you have my permission to ask the respective health care provider/agency, who may release such information to you. I will inform the staff of any changes in my health or medication.

Mobile #:_____ **Email:**_____

Signature of Patient (If under 18 years old, then Parent/Guardian)_____**Date**_____

DDS / Hyg signature(s)_____ Date_____
Additional notes: