GALLERIA
FAMILY DENTAL
ADVANCED DENTISTRY

PATIENT INFORMATION

Welcome to our practice!
This confidential information will help us prepare for your visit.

NAME ◯ MRS ◯ MR ◯ MS ◯ REV ◯ DR	I PREFER TO BE ADDRESSED AS
BIRTHDATE	SS #
ADDRESS	EMAIL
I AM ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPARATED	WHOM MAY WE THANK FOR REFERRING YOU?

HOME PHONE #	CELL PHONE #	WORK PHONE #
EMPLOYER ADDRESS	EMPLOYER NAME	OCCUPATION

We may use an automated appointment reminder system that can send you convenient email, text messages, and/or postcards. We may also call and if necessary leave brief voicemail messages.

If you would prefer **NOT** to receive routine reminders from us via certain methods, please indicate below:

☐ NO TEXT MESSAGES ☐ NO EMAILS ☐ NO CELL PHONE ☐ NO HOME PHONE ☐ NO WORK PHONE ☐ NO POSTCARDS

FAMILY MEMBERS SEEN AS PATIENTS HERE

SPOUSE'S NAME	SPOUSE'S BIRTHDATE

SPOUSE'S SS#	SPOUSE'S CELL PHONE #	SPOUSE'S WORK PHONE #
SPOUSE'S EMPLOYER ADDRESS	SPOUSE'S EMPLOYER NAME	SPOUSE'S OCCUPATION
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE #	EMERGENCY CONTACT RELATIONSHIP

PERSON FINANCIALLY RESPONSIBLE ◯ SELF ◯ SPOUSE ◯ OTHER	RESPONSIBLE PARTY NAME (IF OTHER)	RESPONSIBLE PARTY PHONE # (IF OTHER)	RESPONSIBLE PARTY SS # (IF OTHER)

RESPONSIBLE PARTY ADDRESS (IF OTHER)	RESPONSIBLE PARTY RELATIONSHIP (IF OTHER)

DENTAL INSURANCE COMPANY NAME	DENTAL INSURANCE COMPANY ADDRESS	DENTAL INSURANCE COMPANY PHONE #	GROUP #

CONCERNS I SEE ABOUT ACHIEVING OR MAINTAINING EXCELLENT DENTAL HEALTH ARE:

☐ I SEE NO OBSTACLES ☐ TIME AWAY FROM WORK OR OTHER OBLIGATIONS ☐ FEAR BECAUSE OF PAST DENTAL EXPERIENCES
☐ COST OF TREATMENT ☐ FEAR OF POSSIBLE DISCOMFORT, PAIN, OR INJECTIONS
☐ OTHER (PLEASE EXPLAIN)

I BELIEVE MY PRESENT STATE OF DENTAL HEALTH IS ◯ POOR ◯ FAIR ◯ GOOD ◯ EXCELLENT	I AM AWARE OF THE CURRENT DENTAL TREATMENT THAT I NEED ◯ YES ◯ NO

PLEASE SELECT ONE

◯ I AM SATISFIED WITH MY SMILE ◯ I AM CURIOUS HOW TO IMPROVE MY SMILE ◯ I AM NOT SATISFIED WITH MY SMILE

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HEALTH HISTORY

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MY CURRENT MEDICAL HEALTH IS	I AM UNDER THE CARE OF A PHYSICIAN
◯ EXCELLENT ◯ GOOD ◯ FAIR ◯ POOR	◯ YES ◯ NO
PHYSICIAN NAME	PHYSICIAN PHONE #
PHYSICIAN ADDRESS	

PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDE BOTH PRESCRIPTION & OVER THE COUNTER)

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING

☐ ANEMIA	☐ COLD SORES	☐ FEVER BLISTERS	☐ HIV/AIDS	☐ SCARLET FEVER
☐ ARTHRITIS	☐ COLITIS	☐ GLAUCOMA	☐ HOSPITALIZED	☐ SEVERE OR FREQUENT HEADACHES
☐ ARTIFICIAL JOINT	☐ DIABETES	☐ HEART ATTACK	☐ KIDNEY PROBLEMS	☐ SHINGLES
☐ ARTIFICIAL VALVE	☐ DIFFICULTY BREATHING	☐ HEART MURMUR	☐ MITRAL VALVE PROLAPSE	☐ SINUS PROBLEMS
☐ ASTHMA	☐ DRUG/ALCOHOL DEPENDENCE	☐ HEART SURGERY	☐ PACEMAKER	☐ STROKE
☐ BLOOD TRANSFUSION	☐ EMPHYSEMA	☐ HEMOPHILIA/BLEEDING	☐ PSYCHIATRIC PROBLEMS	☐ TUBERCULOSIS
☐ CANCER	☐ EPILEPSY/SEIZURES	☐ HEPATITIS	☐ RADIATION TREATMENT	☐ ULCERS
☐ CHEMOTHERAPY	☐ FAINTING	☐ HIGH/LOW BLOOD PRESSURE	☐ RHEUMATIC FEVER	☐ VENEREAL DISEASE

PLEASE CHECK ANY OF THE FOLLOWING DRUGS YOU HAVE USED AT ANY TIME

☐ ACTONEL ☐ AREDIA ☐ BIOPHOSPHONATES/BISPHOSPHONATES ☐ BONIVA ☐ DIDRONEL ☐ FOSAMAX ☐ SKELID ☐ ZOMETA

ARE YOU ALLERGIC TO OR HAVE HAD DIFFICULTY WITH ANY OF THE FOLLOWING SUBSTANCES

☐ ASPIRIN ☐ CODEINE ☐ DENTAL ANESTHETIC ☐ ERYTHROMYCIN ☐ LATEX ☐ PENICILLIN ☐ SULFA ☐ TETRACYCLINE

☐ OTHER (PLEASE LIST): _____

WOMEN ONLY

ARE YOU PREGNANT? ◯ YES ◯ NO ARE YOU NURSING? ◯ YES ◯ NO ARE YOU TAKING BIRTH CONTROL? ◯ YES ◯ NO

PLEASE SELECT ONE

◯ I CURRENTLY HAVE NO DENTAL PAIN, JAW PAIN, OR SENSITIVITY ◯ I CURRENTLY HAVE SOME DENTAL PAIN, JAW PAIN, OR SENSITIVITY

PLEASE SELECT ONE

◯ MY MOUTH IS VERY COMFORTABLE ◯ MY MOUTH IS MODERATELY COMFORTABLE ◯ MY MOUTH IS UNCOMFORTABLE

The information provided is accurate & complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

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CAVITY RISK ASSESSMENT

Welcome to our practice!
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PATIENT NAME	DATE

We are committed to helping you prevent cavities. The process of prevention begins with understanding the factors that cause cavities that are present for you. Some of these factors you will have control over and we are happy to discuss ideas to manage them. Other factors are beyond your control, but can be managed by the addition of things like special toothpastes, rinses and mints.

1. Do you get Fluoride in your water, toothpaste or at the dentist? ◯ YES ◯ NO
2. Do you eat sugary foods or drinks between meals? ◯ YES ◯ NO
3. Do you see a dentist regularly? ◯ YES ◯ NO
4. Have you had Chemotherapy or Radiation? ◯ YES ◯ NO
5. Have you had a cavity in the last 3 years? ◯ YES ◯ NO
6. Have you ever lost a tooth due to a cavity? ◯ YES ◯ NO
7. Do you currently have braces? ◯ YES ◯ NO
8. Do you have a dry mouth? ◯ YES ◯ NO
9. Have you or a close family member had a cavity in the last 2 years? ◯ YES ◯ NO
10. Have you or a close family member had a cavity in the last year? ◯ YES ◯ NO

STOP HERE!
(Below Portion To Be Completed With Your Dental Hygienist or Dentist)

1. Unusual Tooth Shapes ◯ YES ◯ NO
2. Visible Plaque ◯ YES ◯ NO
3. Fillings Between Teeth ◯ YES ◯ NO
4. Poor Fitting Fillings or Crowns ◯ YES ◯ NO
5. Exposed Tooth Roots ◯ YES ◯ NO
6. Medications Causing Dry Mouth ◯ YES ◯ NO
7. Other Factors ◯ YES ◯ NO

TOTAL CARIES RISK ◯ LOW ◯ MODERATE ◯ HIGH

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PERIO RISK ASSESSMENT

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PATIENT NAME	DATE

TOBACCO USE

Tobacco use is the most significant risk factor for gum disease.

DO YOU NOW OR HAVE YOU EVER USED THE FOLLOWING:

	AMOUNT PER DAY	NUMBER OF YEARS USED	IF YOU QUIT, LIST YEAR
☐ CIGARETTES			
☐ CIGARS			
☐ PIPES			
☐ CHEW			
☐ E-CIGARETTES			

DIABETES

Gum disease is a common complication of diabetes. Untreated, gum disease makes it harder for patients with diabetes to control their blood sugar.

IF YOU ARE A PATIENT WHO HAS DIABETES

1. Is your diabetes under control? ◯ YES ◯ NO
2. Are you prone to diabetic complications? ◯ YES ◯ NO

How do you monitor your blood sugar? _____

Who is your physician for diabetes? _____

IF YOU ARE NOT A PATIENT WHO HAS DIABETES

Any family history of diabetes? ◯ YES ◯ NO

Have you had any of these warning signs of diabetes?

☐ FREQUENT URINATION ☐ SLOW HEALING OF CUTS ☐ WEAKNESS & FATIGUE
☐ EXCECSSIVE HUNGER ☐ EXCESSIVE THIRST ☐ UNEXPLAINED WEIGHT LOSS

HEART ATTACK & STROKE

Untreated gum disease may increase your risk for heart attack or stroke.

DO YOU HAVE ANY RISK FACTORS FOR HEART DISEASE OR STROKE?

☐ FREQUENT URINATION ☐ SLOW HEALING OF CUTS ☐ WEAKNESS & FATIGUE
☐ EXCESSIVE HUNGER ☐ EXCESSIVE THIRST ☐ UNEXPLAINED WEIGHT LOSS

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

MEDICATIONS

A side effect of some medications can cause changes in your gums.

ARE YOU TAKING OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATION?

Anti-seizure medications (Dilantin, Tegretol, Phenobarbital, etc.) ◯ YES ◯ NO
If YES, are you still taking the anti-seizure medication? ◯ YES ◯ NO
Name of medication: _____
Blood pressure medication (Procardia, Cardizem, Norvasc, Verapamil, etc.) ◯ YES ◯ NO
If YES, are you still taking the blood pressure medication? ◯ YES ◯ NO
Name of medication: _____
Immunosuppressant therapy (Prednisone, Azathioprine, Cyclosporins, Corticosteroids, Asthma Inhalers, etc.) ◯ YES ◯ NO
If YES, are you still taking the immunosuppressant medication? ◯ YES ◯ NO
Name of medication: _____

FAMILY HISTORY & GENETICS

The tendency for gum disease to develop can be inherited.

Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. Your mother, father, or siblings) ◯ YES ◯ NO

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PERIO RISK ASSESSMENT

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HEART MURMUR OR ARTIFICIAL JOINT PROSTHESIS

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.

DO YOU NOW OR HAVE YOU EVER USED THE FOLLOWING

Do you have a heart murmur? ◯ YES ◯ NO

Do you have an artificial joint? ◯ YES ◯ NO

If YES, does your physician recommend antibiotics prior to dental visits? ◯ YES ◯ NO

Name of physician? _____

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

FEMALES/WOMEN

Females can be at increased risk for gum disease at different points in their lives.

Women with osteoporosis have a greater risk for periodontal bone loss.

THE FOLLOWING CAN ADVERSELY AFFECT YOUR GUMS. PLEASE CHECK ALL THAT APPLY.

☐ PREGNANT ☐ MENOPAUSE ☐ TAKING BIRTH CONTROL PILLS

☐ NURSING ☐ INFREQUENT CARE DURING PREVIOUS PREGNANCIES

DO YOU TAKE ANY OF THE FOLLOWING?

Estrogen Replacement Therapy/Hormone Replacement Therapy
(Prempro, Premarin, Premphase, Fosamax, Actonel, Evista, Forteo, etc.) ◯ YES ◯ NO

Name of medication: _____

NUTRITION & STRESS

Your diet has the potential to affect your periodontal health.

High levels of stress can reduce your body's immune defense.

Are you under a lot of stress? ◯ YES ◯ NO

Do you find it difficult to maintain a well-balanced diet? ◯ YES ◯ NO

HAVE YOU NOTICED ANY OF THE FOLLOWING SIGNS OF GUM DISEASE?

☐ BLEEDING GUMS DURING TOOTH BRUSHING
☐ PUS BETWEEN THE TEETH AND GUMS
☐ RED, SWOLLEN OR TENDER GUMS
☐ LOOSE OR SEPARATING TEETH
☐ GUMS THAT HAVE PULLED AWAY FROM THE TEETH
☐ CHANGE IN THE WAY YOUR TEETH FIT TOGETHER
☐ PERSISTENT BAD BREATH
☐ FOOD CATCHING BETWEEN TEETH

Is it important to keep your teeth for as long as possible? ◯ YES ◯ NO

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? ◯ YES ◯ NO

Do you like the color of your teeth? ◯ YES ◯ NO

Do your teeth keep you from eating any specific food? ◯ YES ◯ NO

GALLERIA FAMILY DENTAL ADVANCED DENTISTRY

COSMETIC QUESTIONNAIRE

Welcome to our practice!
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PATIENT NAME	DATE

We love to create and enhance smiles every day in our practice. In order to evaluate your needs and desires as accurately as possible, please help us by answering the following questions, choose any words that may apply, and provide us with any additional information. If you have NO cosmetic concerns or desires, you may skip this section of the paperwork.

1. Rate your smile on a scale from 1 - 10 with 10 being the best smile: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
2. How would you describe the color of your teeth? (dull, stained, etc.) _____
3. Are your teeth crooked or out of line? ◯ YES ◯ NO
4. Are there spaces between your teeth you don't like? ◯ YES ◯ NO
5. Have the biting edges of your teeth become uneven, worn down, or chipped? ◯ YES ◯ NO
6. Do you like the appearance of your dental fillings or crowns? ◯ YES ◯ NO
7. Do your dental fillings or crowns match your other teeth? ◯ YES ◯ NO
8. Are any of your teeth missing? ◯ YES ◯ NO
9. Is there anything else about your smile or teeth that you don't like, would like to change, or would like us to know?

_____

STOP HERE!
(Below Portion To Be Completed With Your Dental Hygienist or Dentist)

1. High Smile Line ◯ LOW ◯ MOD ◯ HIGH
2. Deep Bite ◯ LOW ◯ MOD ◯ HIGH
3. Functional Risk with Aesthetic Treatment ◯ LOW ◯ MOD ◯ HIGH
4. Ortho prior to Aesthetic Treatment ◯ LOW ◯ MOD ◯ HIGH
5. Midline to Face ◯ LOW ◯ MOD ◯ HIGH
6. Upper Midline to Lower Midline ◯ LOW ◯ MOD ◯ HIGH
7. Overall Aesthetic Risk ◯ LOW ◯ MOD ◯ HIGH

COSMETIC NEED ◯ LOW ◯ MODERATE ◯ HIGH

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OCCLUSAL RISK ASSESSMENT

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PATIENT NAME	DATE

DO YOU HAVE PROBLEMS WITH YOUR JAW JOINT (PAIN, SOUNDS, LIMITED OPENING, LOCKING, POPPING)?

DO YOU FEEL LIKE YOUR LOWER JAW IS BEING PUSHED BACK WHEN YOU BITE YOUR TEETH TOGETHER?

DO YOU AVOID OR HAVE ANY DIFFICULTY CHEWING GUM, CARROTS, NUTS, BAGELS, PROTEIN BARS, OR OTHER HARD, DRY FOODS?

HAVE YOUR TEETH CHANGED IN THE LAST 5 YEARS (i.e. BECOME SHORTER, THINNER, OR WORN)?

ARE YOUR TEETH BECOMMING MORE CROWDED OR DEVELOPING MORE SPACES OVER THE LAST 5 YEARS?

DO YOU KNOW YOURSELF TO HAVE MORE THAN ONE BITE?

DO YOU CHEW ICE, BITE YOUR NAILS, USE YOUR TEETH TO HOLD THINGS, OR HAVE ANY OTHER CHEWING/BITING HABITS?

DO YOU CLENCH YOUR TEETH IN THE DAYTIME OR MAKE THEM SORE?

DO YOU HAVE PROBLEMS WITH SLEEP OR WAKE UP WITH SORENESS OR SENSITIVITY IN YOUR TEETH?

DO YOU WEAR OR HAVE YOU EVER WORN A BITE APPLIANCE?

DO YOU CLENCH OR GRIND YOUR TEETH WHEN YOU ARE STRESSED?

STOP HERE!
(Below Portion To Be Completed With Your Dental Hygienist or Dentist)

1. Significant Wear Present Relative to Age? ◯ LOW ◯ MOD ◯ HIGH
2. Load Test? ◯ LOW ◯ MOD ◯ HIGH
3. Constricted Chewing Pattern? ◯ LOW ◯ MOD ◯ HIGH
4. Anterior Wear? ◯ LOW ◯ MOD ◯ HIGH
5. Posterior Wear? ◯ LOW ◯ MOD ◯ HIGH
6. Appliance Therapy Likely? ◯ LOW ◯ MOD ◯ HIGH

OVERALL OCCLUSAL RISK ASSESSMENT ◯ LOW ◯ MODERATE ◯ HIGH

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Note: You may refuse to sign this acknowledgment.

I, _____ have recieved a copy of this office's Notice of Privacy Practices.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ INDIVIDUAL REFUSED TO SIGN
- ☐ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT
- ☐ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGMENT
- ☐ OTHER (PLEASE SPECIFY): _____

SIGNATURE OF OFFICE REPRESENTATIVE	DATE