Date:_____ **Dr. Caroline Y. Cesar Inc.** Account #:_____

MEDICAL ALERT: ☐Perio ☐Allergies:_____
☐PRE-MEDICATE:_____ ☐PRE-SEDATE:_____

Please fill out as completely as possible

Name:_____ ☐M☐F Birth date:_____ Home Phone: _____
(Miss, Ms, Mrs, Mast, Mr, Dr) (Day/Month/Year) Cell Phone: _____

Address: _____ City:_____ Postal Code: _____
Employer:_____ Occupation:_____ Business Phone:_____
Spouse's Name:_____ Employer:_____ Business Phone:_____
Family Physician:_____ Phone:_____ Location:_____
In case of emergency, please notify:_____ Telephone:_____ Relationship:_____
Your Email_____ Whom may we thank for referring you?_____

The above medical and dental history is complete to date. I also understand that the total payment of the dental service is my responsibility and not that of the insurance company:

_____
Patient's Signature or Parent/Guardian

INSURANCE HISTORY: ☐**Insurance** ☐**No Insurance**

1st Insurance:_____ Deductible:_____
Policy Holder:_____
Group #:_____
ID#:_____
A=_____ A Limit=_____
B=_____ B Limit=_____
C=_____ C Limit=_____
R/C=__6months 9months 12months_____
R/P-S/C limit=_____
Comps on molars=_____
Comps on primary=_____
FS=____Age Limit:_____Primary:_____Permanent:_____

2nd Insurance:_____ Deductible:_____
Policy Holder:_____
Group #:_____
ID#:_____
A=_____ A Limit=_____
B=_____ B Limit=_____
C=_____ C Limit=_____
R/C=__6months 9months 12months_____
R/P-S/C limit=_____
Comps on molars=_____
Comps on primary=_____
FS=____Age Limit:_____Primary:_____Permanent:_____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth crowding or developing spaces? _____ ☐ ☐
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
28. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
30. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
32. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
34 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ codeine		
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ any other medications _____		
3. heart problems _____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever _____	☐	☐
6. scarlet fever _____	☐	☐
7. high blood pressure _____	☐	☐
8. low blood pressure _____	☐	☐
9. a stroke _____	☐	☐
10. artificial prosthesis (i.e. heart valve or joints) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut _____	☐	☐
13. emphysema _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid or parathyroid disease _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol _____	☐	☐
23. diabetes _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

TMJ HEALTH QUESTIONNAIRE

CHIEF CONCERN _____

DATE OF ONSET _____

JAW JOINT SYMPTOMS

Do you have pain in your jaws? Right, left or both	Y	N	Does your jaw feel tired after a big meal?	Y	N
Are you capable of chewing gum?	Y	N	Are there any foods you avoid eating?	Y	N
Are you capable of chewing a bagel?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Do you hear noises in your jaw joint	Y	N	Do you ever get dizzy?	Y	N
Has your jaw ever locked open or closed?	Y	N	Does your jaw ache when you open wide?	Y	N
Can you make your jaw pop or crack?	Y	N	Do you ever feel faint?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N	Do you ever feel nauseated?	Y	N

PAIN SYMPTOMS

Do you get headaches?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you get migraine headaches?	Y	N	Do you get headaches in the front or back of your head?	Y	N
Do you frequently have neck aches or stiff neck muscles	Y	N	Do you clench your teeth during the day?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N	Do you think you clench your teeth at night?	Y	N
Do you have trouble sleeping soundly?	Y	N	Do you think you grind your teeth when asleep?	Y	N
Are your jaws tired when you awaken?	Y	N	When are your pain symptoms the worst?		
Are your teeth sore when you awaken?	Y	N			
Have your wisdom teeth been extracted?	Y	N	Does anything make you feel better?		

What medications, if any, are you taking? _____

How often do you take medication for relief of pain? _____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw	Y	N	Have you ever been involved in any serious accidents, such as a car accident? Details:	Y	N
Any whiplash neck injuries	Y	N			

EAR AND EYE SYMPTOMS

Do you have pain in either ear?	Y	N	Do you wear glasses or contacts?	Y	N
Do you suffer from any loss of hearing?	Y	N	Are there times when your eyesight blurs?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N	Do you get pain in, around or behind either eye?	Y	N
Do you hear ringing, buzzing, or hissing sounds in either ear?	Y	N			

BREATHING

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N	Have you been diagnosed with Sleep Apnea?	Y	N
Do you snore at night?	Y	N	Have you had a sleep study done at a Sleep Clinic (hospital)?	Y	N

BioRESEARCH Assoc. Inc. 9275 N. 49th Street #150 Milwaukee WI 53223 www.BioRESEARCHinc.com

Click SUBMIT button to send your completed form to our office (only works in Acrobat).
If you're having problems, you can email this PDF to bourquindental@telus.net

SUBMIT