Instructions

Please fill out the form as completely as possible. When you're done, you have two choices. Click the button below to either:

1) Click the "Submit by Email" button and send this document to our office; or
2) Print the form and bring it with you to your appointment

Nolan Freund Dental Professionals
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Welcome

Patient Information

SSN _____ Current Date 8/7/19

First Name _____ Initial ____ Last Name _____

Address _____

City _____ State ____ Zip Code _____

Sex _____ Marital Status _____ Birthday _____

Occupation _____

Employer _____

Contact Information

Email _____

Home Phone _____

Work Phone _____

Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:
(Specify someone who does not live in your household)

Name _____

Home Phone _____

Relationship _____

Questionnaire

Whom may we thank for referring you?

What is important to you when choosing your new dentist?

Are you satisfied with your tooth appearance?	◯ Yes	◯ No
Are you satisfied with your tooth color?	◯ Yes	◯ No
Do you feel your teeth are crowded?	◯ Yes	◯ No
Do you feel your teeth are poorly aligned?	◯ Yes	◯ No
Do you feel your teeth are protruding?	◯ Yes	◯ No
Do you suffer from dental decay in your front teeth?	◯ Yes	◯ No
Do you have non-esthetic front teeth restorations?	◯ Yes	◯ No
Do you have fractures in your front teeth?	◯ Yes	◯ No
Are you hiding your teeth while smiling?	◯ Yes	◯ No

Dental Insurance

Relationship to Patient? _____

Insurance Company _____

Subscriber's Name _____

Subscriber's Birthday _____ SSN _____

Group # _____

Medications

List any medications you are currently taking and the correlating diagnosis:

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Skin reaction to jewelry
- ☐ Any known metal allergies
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (Specify)

Dental History

Reason for Today's Visit

Former Dentist

City/State

Date/Last Visit

Date/Last Dental X-Rays

Please select "Yes" or "No" to indicate if you have had any of the following:

Bad breath	◯ Yes ◯ No	Burning sensation on tongue	◯ Yes ◯ No
Bleeding Gums	◯ Yes ◯ No	Chew on one side of mouth	◯ Yes ◯ No
Blisters on Lips or Mouth	◯ Yes ◯ No	Smoking or Tobacco use	◯ Yes ◯ No
		Clicking or popping jaw	◯ Yes ◯ No
		Dry mouth	◯ Yes ◯ No
		Fingernail biting	◯ Yes ◯ No
		Food collection between teeth	◯ Yes ◯ No
		Grinding Teeth	◯ Yes ◯ No
		Loose teeth or broken fillings	◯ Yes ◯ No
		Mouth breathing	◯ Yes ◯ No
		Mouth pain, brushing	◯ Yes ◯ No
		Orthodontic treatment	◯ Yes ◯ No
		Pain around ear	◯ Yes ◯ No
		Periodontal treatment	◯ Yes ◯ No
		Sensitivity to cold	◯ Yes ◯ No
		Sensitivity to heat	◯ Yes ◯ No
		Sensitivity to sweets	◯ Yes ◯ No
		Sensitivity when biting	◯ Yes ◯ No
		Sores or growths in your mouth	◯ Yes ◯ No

How often do you brush? _____

How often do you floss? _____

Health History

Physician's Name _____ City/State _____ Date/Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine?) ◯ Yes ◯ No

Please select "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No
Arthritis, Rheumatism	◯ Yes ◯ No	Fainting or dizziness	◯ Yes ◯ No	Respiratory Disease	◯ Yes ◯ No
Artificial Heart Valves	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Artificial Joints	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Shortness of breath	◯ Yes ◯ No
Back Problems	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No
Bleeding abnormally, with extractions or surgery	◯ Yes ◯ No	Hepatitis Type ____	◯ Yes ◯ No	Skin rash	◯ Yes ◯ No
		Herpes	◯ Yes ◯ No	Special diet	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	High blood pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Swollen feet or ankles	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	Jaw Pain	◯ Yes ◯ No	Swollen neck glands	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Thyroid problems	◯ Yes ◯ No
Circulatory Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Congenital Heart Lesions	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cortisone Treatments	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tumor or growth on head or neck	◯ Yes ◯ No
Cough, persistent or bloody	◯ Yes ◯ No	Nervous Problems	◯ Yes ◯ No	Ulcer	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Weight loss, unexplained	◯ Yes ◯ No
Do you wear contact lenses?	◯ Yes ◯ No				

Women Only:

Are you pregnant? ◯ Yes ◯ No Due date _____

Are you nursing? ◯ Yes ◯ No

Taking birth control pills? ◯ Yes ◯ No