Valentina Pasquantonio, DDS, FAGD 9 Damonmill Square, Unit 4B (978) 369-2500
Concord, MA 01742

Name____ Date___________

Address____City______________________________

State_____ Zip______ ____Telephone: Home____

Telephone: Work____________________________Telephone:Cell________________________

E-mail______________________ Date of Birth___________________

We are about to begin a program designed to restore your mouth to a condition of health, but we will need your complete cooperation if we are to succeed. To aid us in thoroughly and accurately evaluating your present dental condition, please fill out this questionnaire at your leisure and return it to our office in the enclosed envelope prior to your examination visit. This form will become an important part of your office record and will be held in the strictest of confidence. Thank you.

Do you have any special concerns about your mouth? YES/NO
What are they? ____

How long has it been since your last dental visit? ____
What was accomplished at that time? ____
How frequently have you visited a dentist? ____

When was the last time you had a complete x-ray series (16-18 films)____________________________
How long has it been since you had x-rays of your back teeth____________________ (the kind you bite on / one on each side)?

Do you use your automobile seat belts? YES/NO

How often do you brush your teeth? ____
Do you brush vigorously or lightly? ____
Do you avoid any part of your mouth while brushing? ____
How often do you use dental floss or tape? ____
Do you use any other aids: for example stim-u-dent, rubber tip stimulators, etc.? ______________________
Have you ever received special instructions on oral hygiene? ____by whom?____________when_______
Do you have bad breath?_______________An unpleasant taste in your mouth?______________________

Do you ever have pain or ringing in your ears?____
Do you have sensitivity in your mouth because of heat, cold, or sweets?________If so where?___________

Do you experience discomfort in any part of your mouth or in any teeth while biting or chewing? YES/NO
If "yes"where?____
Does food catch between your teeth? YES/NO If "yes"where?____
Do your gums feel tender or irritated? YES/NO If "yes" where?______________________________________

Do you hear a clicking or snapping noise when you chew? YES/NO If "yes" when did you first notice this noise____

Do you ever experience jaw pain?____
Do you experience frequent headaches/ migrains?________________How often?____________________
Do you ever experience a burning sensation of your tongue?______________________________________

Are you in the habit of biting your nails or any other hard object such as bobby pins, nails, pipe stems etc.?____
Do you smoke?_______________What?____________________How much?__________________________

Do you clench your teeth during the day?_________________Night?________________________________

Have you lost any teeth other than wisdom teeth?____
Have you had them replaced?____________________________Fixed bridge?_______________________
Removable partial denture?_________________________________Full denture?_____________________
Have you ever had orthodontic treatment? (braces)YES/NO when?_______________________________
Have you noticed any tooth mobility? ________________________If so, where? ______________________
Any swelling in your mouth? YES/NO If "yes" where?____
Have you ever had the vitality of your teeth tested? ____
Have you ever had the nerves of any teeth removed (root canal)? YES/NO If "yes" why was it necessary?____

In the past have you had the opportunity to choose your dental treatment? _____If so what was your choice?
____
Do you frequently have silver or porcelain restorations replaced due to washing out or breakage?____________

Do you prefer an anesthetic for cavity preparation?____
Have you ever had nitrous oxide? ____________________would you prefer it?________________________

Are you satisfied with your past dentistry? ____
Were you referred to our office: YES/NO If "yes" by whom?____
(If by your physician or psychologist give name) ____

How long has it been since you had a complete medical examination?________________________________
Are you now under the care of a physician? No____ Yes____ If "yes" for what reason?
____
Name of your physician:____
Name of your previous dentist:____

LIST ANY DRUG ALLERGIES:

____

____

Are you taking any medicines or drugs? YES/NO If "yes" please list

____

Are you taking any of the following drugs?

Drugs that cause: Gingival hyperplasia / Over grown gums
Calcium channel blocker (used treatment hypertension and other diseases.)
___A. Procardia (nifedpine)
___ B. Cardiazem
___Diltiazem
___Vorapomil
___Norvasc
___Amlodipine
___Dilanten ___ causes hyperplasia___Cyclosporine: organ transplant
Drugs that cause: Xerostomia (dry mouth) = caries problems
(Worst: psychiatric meds) (Very worst: tricyclic anti depressants):
___Elavil ___ amitripyline ____ Proza ___Zoloft
___Pamelor ___ Tofranil ____ imipramione
___ nortriptyline ___ Paxil ____Buspa ____Wellbutrin

When was the last time you were in the hospital over night?____________________________

For what reason?____
Date of last surgery/operation___________Were you put to sleep for the surgery/operation YES/NO
Have you ever been treated for alcohol or drug abuse? _____________When______________________

Do you have any known allergies? ______________________to what____________________________

Have you ever had:
x-ray therapy ?_______ anemia?_____ diabetes? ______ arthritis? ________
rheumatic fever ? _______high blood pressure ? __________ heart condition ?_______
excessive bleeding from a cut? _______ hepatitis ?______ cancer? _______ scarlet fever? _____
stroke? ______ tuberculosis?_________ ulcers?_________
Are you HIV positive? _____
For women only: are you pregnant?_________do you take birth control pills?_________other hormones?_____
Additional information:
Give us your attitude towards dentistry in general____________________________________

____

____

Signature

Doctor's use only:

Patient's Goals:

Patients dental story:

Past:

Current:

Future:

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Dental Insurance Information*

Name____Date________________

PART A

Your employer: ____

Insurance company name:____

Address:____

City_________________________________ State ________________ zip________

Group number :____

Your Social Security number :____

Is dental insurance in your name? ___________if no go to part B__________________________________

PART B

INSURED PARTY'S INFORMATION

Name :____

Address (if different from yours):____

City:______________________________state:________________________Zip :_________

Date of birth: _____________ social security number: _____________________________

Employer: ____

PART C
Your Signature____date________________

***ON YOUR FIRST VISIT WE ARE REQUIRED TO SEE A PHOTO ID WITH YOUR INSURANCE CARD**