KYLE D. GILL, DDS
DENTISTRY FOR YOUR FAMILY

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Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME_____ PREFERRED NAME_____

☐ Male ☐ Female Social Security No._____-_____-_____ Birthdate_____/_____/____

Mailing Address_____ Email _____

City_____ State_____ Zip Code_____ Home Phone No. (_____) _____

Cell Phone No. (_____)_____ How should we contact you? ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text

Patient Occupation_____ Employer_____ Work Phone (_____)_____

Name of Spouse_____ Birthdate_____/_____/_____ SSN_____

Spouse Occupation_____ Employer_____ Work Phone (_____) _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name_____ Home Ph. No. (_____)_____ Work Ph. No. (_____)_____

Relationship to patient _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Is there anyone you would like to give us permission to speak to about your dental care? _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover. _____
Initials

I have been given and understand the Kyle Gill Dentistry For Your Family HIPPA Notices of Privacy Act.

Signature _____ Date _____

Primary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co. _____ Group# _____
Insurance Phone No. _____
Insurance Member ID # _____
Subscriber D.O.B. _____

Secondary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co. _____ Group# _____
Insurance Phone No. _____
Insurance Member ID # _____
Subscriber D.O.B. _____

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 or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel,gold,silver,_____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve,repaired heart defect(PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to slight cut (INR>3.5) _____	☐	☐
13. pneumonia,emphysema,shortness or breath,sarcoidosis	☐	☐
14. chronic ear infections,tuberculosis,measles,chicken pox	☐	☐
15. asthma _____	☐	☐
16. breathing or sleeping problems (e.g.,sleep apnea snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid or parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes(HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g.,celiac disease, gastric reflux,bullimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease(e.g.,rheumatoid arthritis,lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders(ADD/ADHA,prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy,immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g.,fever,chills,new cough,or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker or smoked previously or use smokeless tobacco	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostrate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/developlment delay, or other treatment that may possibly affect your dental treatment. (i.e.Botox, Collagen Injections) _____

_____

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 _____

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? Scale of 1 to 10 (very) _____ ☐ ☐
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 reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma? _____ ☐ ☐

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 recesssion? _____ ☐ ☐
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 or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem tto 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 do you avoid brusing any part of your mouth? _____ ☐ ☐
18. Do you have grroves 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 back teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum,carrots,nuts, bagels, baguettes, protien bars, or other hard, dry foods? _____ ☐ ☐
24. In the past 5 years, have your teeth changed(become shorter, thinner or worn) or has your bite changed? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze,tap your teeth together,or shift your jaw to make your teeth fit together? ☐ ☐
28. Do you place your tongue between your teeeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep(ie. restlessness or teeth grinding),wake up with a headache or an awareness of your teeth? ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the about the appearance of your teeth that you would like to change(shape, color, size)? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previosu dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____