GREENBROOK DENTAL GROUP, S.C.

Get Acquainted Questionnaire: Confidential

So that we may treat you safely and effectively,
please answer all questions fully.

Updates:	w/ initials
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____

(office use only)

Name _____ Age _____ Date of Birth ____/____/____

MEDICAL HISTORY

When was your last physical exam? _____ Reason for exam? _____

Are you seeing a physician at this time? *yes / no* If so, for what? _____

Physician's name: _____ Party to notify in case of emergency: _____

Please list any medications (prescription or non-prescription) you are taking, and what they are for:

_____ _____ _____

_____ _____ _____

If you take more medications than fit on this page, please let us copy your physician's list or use the back of this page.

Are you allergic, or do you react to anything (drugs, food, etc.)? *yes / no* If so, what? _____

_____

Do you now, or have you ever had: (check only if **yes**)

- □ Arthritis Type: _____
- □ Diabetes
- □ Asthma
- □ Tuberculosis
- □ Heart problems/murmur
- □ Rheumatic fever
- □ Heart valve problems
- □ Need for antibiotics before dental procedures
- □ Pacemaker
- □ High blood pressure
- □ Pain in chest on exertion
- □ Dementia / Alzheimer's
- □ Abnormal bleeding
- □ Anemia / blood transfusion
- □ Osteoporosis / bone issues
- □ Sleep apnea or disorder
- □ AIDS or HIV
- □ Artificial Joint: _____
- □ Do you smoke? What? _____ How much? /day
- □ Hepatitis / Jaundice
- □ Liver disease
- □ Thyroid problem
- □ Chronic pain in: _____
- □ Acid Reflux / GERD
- □ Heart burn
- □ Nervous disorder/ psychiatric care
- □ Syndrome/Disease/Disorder that is not listed here (name): _____
- □ Malignancy or tumor Location: _____
- □ Radiation therapy Location: _____
- □ (female) Is there any chance you could be pregnant
- □ History of drug/alcohol abuse
- □ Fainting spells
- □ Epilepsy / Seizures

DENTAL HISTORY

What is your main problem / reason for coming? _____

Do you currently have dental related pain? *yes / no* _____

How do you feel about the condition of your teeth? _____

How do you feel about your past dental experiences? _____

When was your last dental visit? _____ Do you have any recent X-rays (≤ 2 yrs old) *yes / no*

Do you now, or have you ever had: (check if only **yes**)

HABITS/MISC:
- □ Clenching
- □ Grinding *day / night*
- □ Night guard or splint
- □ Jaw, neck, ear pain
- □ Cold sores / canker sores
- □ Gagging problems
- □ Problems with anesthetic

DISEASE:
- □ Any recent decay
- □ Decay around old fillings
- □ Dry mouth
- □ Root Canal Work
- □ Periodontal (Gum) disease
- □ Gum surgery
- □ Regular cleanings

CROWNS/BRIDGES:
- □ Broken teeth from chewing
- □ Broken teeth from trauma
- □ Crown on any tooth
- □ Any fixed bridge(s)
- □ Broken/failed crown
- □ Broken/failed bridge
- □ Orthodontics (braces)

REMOVABLE DEVICES:
- □ Removable partial denture
- □ Complete Denture
- □ Reline
- □ Broken denture
- □ Dental implant(s)
- □ Missing teeth
- □ Teeth bleached

HYGIENE AND DIET HISTORY

How often do you brush? _____ per day/week What kind of toothpaste? _____

Do you eat or drink between meals? yes / no Do you use dental floss? yes / no / occasionally

On average, how many times per day do you eat or drink anything other than water (snacks, coffee, soda, etc. + meals): _____

What other oral hygiene products do you use? _____

How often do you consume citrus fruits or carbonated beverages? _____ per day / week

____/____/____ _____

Today's date Your signature

Thank you for taking time to complete this form honestly and accurately!