ROBERT D. ARGENTIERI, DDS

Dental History

Previous Dentist

Dentist Name:	Dental Practice Name:	Phone: - -

Address:	City:	State:	ZIP Code:

What did you like about your last dentist?	What caused you to leave your last dentist?

Last Dental Visit

Last Dental Visit (m/y): /	What were you treated for?	Treatment complete? ❍Yes ❍No

What was done at your last dental visit?	Last X-Rays: /	Last Full-Mouth X-Rays: /	Last Cleaning: /

Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?
Regularly	Yes After every meal	Yes After every meal

Please list other dental hygeine aids (Interplak, toothpicks, etc.) that you use:	Are you interested in regular hygiene cleanings?
	Yes

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

Yes

What is the main reason for your visit today?

❑ Tooth Pain ❑ Check-up ❑ Cleaning ❑ Whitening ❑ Cosmetic Dentistry
❑ Sedation Dentistry ❑ Restorative Dentistry ❑ Other:

What would you like to learn more about?

❑ Whitening ❑ Cosmetic Dentistry ❑ Sedation Dentistry ❑ Implants ❑ Bridges ❑ Veneers
❑ Dentures ❑ Other:

Dental Concerns

Check all that apply.

Teeth

❑ Broken or chipped	❑ Loose/missing filling	❑ Missing teeth	❑ Sensitive to sweets
❑ Crooked	❑ Loose teeth	❑ Mouth sores	❑ Blisters on lips/mouth
❑ Decay	❑ Tooth pain	❑ Sensitive to cold	❑ Orthodontic treatment
❑ Difficulty chewing	❑ Food trap areas	❑ Sensitive to heat	❑ Bad taste in mouth
❑ Discolored	❑ Grinding or clenching	❑ Sensitive when biting	

Gums

❑ Bad breath	❑ Abscessed	❑ Sore	❑ Receding
❑ Red (discolored)	❑ Bleeding	❑ Swollen	❑ Periodontal treatment

Facial/Jaw Pain

❑ Frequent headaches	❑ Pain in temples	❑ Jaw injury	❑ Pain around ear
❑ Avoid certain foods	❑ Jaw locks open/closed	❑ Head injury	
❑ Popping/clicking	❑ Pain in jaw	❑ Neck injury	

Other Concerns

❑ Smoking/dipping	❑ Orthodontic treatment	❑ Snoring
❑ Biting cheeks or lip	❑ Burning tongue	❑ Teeth straightening
❑ Popping/clicking	❑ Tooth replacement	❑ Retainer
❑ TMJ	❑ Fractured tooth syndrome	❑ Dry mouth
❑ Tooth-colored fillings	❑ CPAP	❑ Wisdom teeth extraction
❑ Wisdom teeth	❑ Implants - Tooth #:	❑ Cosmetics
❑ Nail-biting	❑ Jaw locks open/closed	❑ Smile makeover
❑ Sleep apnea	❑ Stain	❑ Dental phobias
❑ Limited orthodontics	❑ Chew on one side	

Does food tend to get caught between your teeth? If yes, where?

Yes

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

Yes

Have you ever had:

Check all that apply.

❑ Orthodontic treatment	❑ Periodontal treatment	❑ Your bite adjusted
❑ Oral surgery	❑ Your teeth ground	❑ A bite plate or mouth guard

❑ Any canker sores or cold sores on your lips, tongue, gums, or body

❑ A serious injury to the mouth or head? If yes, please describe including cause:

Ratings

1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures?
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your sensitivity to dental cleaning appointments?
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep?
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 being low, 5 being high), if you snore, how would you rate the severity of your snoring?

Miscellaneous

Has fear ever been an issue for you in a dental office? ❍Yes ❍No

Has time ever been a factor in getting your dental work done? ❍Yes ❍No

Has the cost of dental treatment been a concern for you? ❍Yes ❍No

If yes, how can we help?

Tell us about your good dental experiences/visits:	Tell us about your bad dental experiences/fears:

What do you like most about your teeth/smile?

Is there anything you don't like about your teeth/smile?

Is there anything you'd like to change about your teeth/smile?

What are your long-term dental goals? How would you like your teeth to feel and look?

What are your short-term dental goals?

Do you have any upcoming event or circumstances (such as weddings, major surgeries, etc.) we should/need to know about? If yes, what and when?

Yes

Is there anything else you feel we should know?

Medical History

How is your general health? ❍Good ❍Fair ❍Poor

Are you currently under medical treatment? If yes, what for?

Yes

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Yes

Physician's Name:	Phone: - -	Last Visit: /

Address:	City:	State:	ZIP Code:

Do we have permission to contact your doctor regarding your care? ❍Yes ❍No

Have you ever had:

Check all that apply.

- ❑ Arthritis
- ❑ Arteriosclerosis
- ❑ Birth defects
- ❑ Cancer
- ❑ Emotional problems
- ❑ Head or face injury
- ❑ Heart murmur/trouble
- ❑ History of substance abuse/drug addiction
- ❑ Kidney problems
- ❑ Numbness of arms or hands
- ❑ Swollen, still painful joints
- ❑ Allergies
- ❑ Asthma
- ❑ Blood disease
- ❑ Diabetes
- ❑ Endocrine problems
- ❑ Intestinal disorders
- ❑ Hepatitis A, B, or C
- ❑ Hypertension (high blood pressure)
- ❑ Liver problems
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Anemia
- ❑ Bruise easily
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Seizures
- ❑ Fainting
- ❑ Hearing disorders
- ❑ High or low blood sugar
- ❑ Hypotension (low blood pressure)
- ❑ Nervous disorder
- ❑ Rheumatic fever
- ❑ Heart attack/stroke
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Artificial valves
- ❑ Congenital heart defect
- ❑ Mitral valve prolapse
- ❑ Artificial bones/joints
- ❑ Shingles
- ❑ HIV/AIDS
- ❑ Blood transfusions
- ❑ Fever blisters
- ❑ Sinus problems
- ❑ Severe/frequent headaches
- ❑ Cancer/chemotherapy
- ❑ Radiation treatments
- ❑ Psychiatric problems
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Hemophilia
- ❑ Abnormal bleeding
- ❑ Ulcers/colitis
- ❑ Difficulty breathing
- ❑ Hospitalized for any reason
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Thyroid disease
- ❑ Angina
- ❑ Artificial hip/joints
- ❑ Gout
- ❑ Chest pain
- ❑ Circulatory problems
- ❑ Cold sores
- ❑ Congenital heart lesion
- ❑ Cortisone medicine
- ❑ Convulsions
- ❑ Herpes
- ❑ Leukemia
- ❑ Excessive thirst
- ❑ Hay fever
- ❑ Heart disease
- ❑ Hives/skin rash
- ❑ Hypoglycemia
- ❑ Irregular heartbeat
- ❑ Lung disease
- ❑ Osteoporosis
- ❑ Pain in jaw joints
- ❑ Parathyroid disease
- ❑ Recent weight loss
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ Sickle cell anemia
- ❑ Sinus trouble
- ❑ Tattoos/body piercing
- ❑ TMD/TMJ (jaw pain)
- ❑ X-ray or cobalt treatment
- ❑ Yellow jaundice
- ❑ Chronic fatigue syndrome
- ❑ Cough-persistent or bloody
- ❑ Latex sensitivity
- ❑ Smoker
- ❑ Swelling of feet/ankles
- ❑ Swollen neck glands
- ❑ Tonsillitis
- ❑ Tumor or growth on head/neck
- ❑ Easily winded
- ❑ Anaphylaxis
- ❑ Alzheimer's disease
- ❑ Frequent diarrhea
- ❑ Genital herpes
- ❑ Renal dialysis
- ❑ Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- ❑ Acrylic
- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Dental anesthetics
- ❑ Erythromycin
- ❑ Iodine
- ❑ Latex rubber
- ❑ Metals
- ❑ Nitrous oxide
- ❑ Novocaine
- ❑ Penicillin/antibiotics
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Tetracycline
- ❑ Valium
- ❑ Xylocaine

Are you being/have you ever been treated for cancer of any kind? If yes, please explain:
Yes

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ❍Yes ❍No

Do you take or have you taken Phen-Fen or Redux? ❍Yes ❍No

Do you smoke or chew tobacco? ❍Yes ❍No

Do you wear contact lenses? ❍Yes ❍No

Are you on a special diet? ❍Yes ❍No

Have you lost or gained more than 10 pounds in the past year? ❍Yes ❍No

Do you use more than two pillows to sleep? ❍Yes ❍No

Have you ever had any excessive bleeding requiring special treatment? ❍Yes ❍No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? ❍Yes ❍No

Have you been treated in a hospital in the last five years? ❍Yes ❍No

If female, please mark if you are:
❑ Pregnant - If so, please enter your due date or week #:
❑ Trying to get pregnant ❑ Nursing ❑ On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? ❍Yes ❍No

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use:
Reviewed by: Title: Date: / /