DIABLO
CREEK
DENTISTRY

ELIZABETH MIER, DDS · KEITH BRADBURN, DDS

Name: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms _____
First Name Last Name

_____ _____ _____ _____
Address City State Zip

Home: ( ) _____ **Work:** ( ) _____ **Cell:** ( ) _____

Date of birth: _____ **SS#:** _____ **E-Mail:** _____

_____ ( ) _____
Employer's Name Phone

_____ _____ _____ _____
Address, including suite # City State Zip

Are you happy with your smile? _____

Is anything in your mouth bothering you or causing you discomfort right now? Yes ☐ No ☐

Is yes, please explain: _____

Are your teeth sensitive to hot, cold, sweets, or biting pressure? _____

How often do you brush? 1 x day ☐ 2 x day ☐ More ☐

Do you use a manual or electric toothbrush? _____

Do you floss? Yes ☐ No ☐

Do your gums bleed when you brush or floss? Yes ☐ No ☐

Do you have any teeth where food gets stuck or floss shreds? Yes ☐ No ☐

Would you like to have whiter teeth? **Yes** ☐ **No** ☐

- **If you have used whitening products or methods in the past, please tell us what you have tried.** _____

Are you concerned with the way your breath smells? **Yes** ☐ **No** ☐

Please provide the name and contact information for your former dentist.

_____ ( ) _____

Name **Phone**

_____ _____ _____ _____

Address **City** **State** **Zip**

<u>Important Dates</u>

Date of last Professional Cleaning _____
Date of last Bitewing Digital Images* _____
Date of last Full Mouth Digital Images* _____

*** Please contact your previous dentist to authorize release of all digital images or x-rays and request that a copy be forwarded to our office prior to your first visit.**

Has your previous dentist advised you of any areas of concern? **Yes** ☐ **No** ☐

If so, please explain. _____

How often do your have your teeth cleaned each year? _____

Have you ever had any of the following?

Periodontal (Gum) Treatment	**Yes** ☐	**No** ☐
Root Canal Therapy	**Yes** ☐	**No** ☐
Orthodontics (Braces)	**Yes** ☐	**No** ☐
Oral Surgery	**Yes** ☐	**No** ☐

Have you ever had pain in your jaw joint (TMJ)? **Yes** ☐ **No** ☐

Do you clench or grind your teeth? **Yes** ☐ **No** ☐

Do you have headaches or ringing in your ears? **Yes** ☐ **No** ☐

Have you ever worn a night guard? **Yes** ☐ **No** ☐

Are you now under a physicians' care? If so, please tell us for what condition.

_____

Please tell us if you are taking drugs, medications, vitamins at this time.

	Name	Reason
1.		
2.		
3.		
4.		
5.		

Have you ever been told to take antibiotics before dental treatments or teeth cleaning? Yes ☐ No ☐

Do you smoke tobacco products? Yes ☐ No ☐ **If so, how much?** _____

Have you ever had an unusual reaction to any of the following? If you answer yes to any of the below, please give us more information (e.g. which antibiotics you are allergic to and what reaction you've had).

			Name of Substance	Reaction
Antibiotics	Yes ☐	No ☐		
Aspirin, Advil or other anti-inflammatory medicines	Yes ☐	No ☐		
Base metals, e.g. nickel, lead	Yes ☐	No ☐		
Codeine or other pain medicines	Yes ☐	No ☐		
Dental Anesthetics "Numbing"	Yes ☐	No ☐		
Dental Materials	Yes ☐	No ☐		
Latex	Yes ☐	No ☐		
Nitrous Oxide	Yes ☐	No ☐		
Other	Yes ☐	No ☐		

Have you received treatment for drug or alcohol abuse? Yes ☐ No ☐

Have you ever taken Redux or Phen-Phen? Yes ☐ No ☐

For Women Only:

Are you pregnant? Yes ☐ No ☐ **Are you nursing?** Yes ☐ No ☐

Do you take birth control pills? Yes ☐ No ☐

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal bleeding (Prolonged)	☐	☐	**Hay Fever**	☐	☐	**Pacemakers**	☐	☐
Anemia	☐	☐	**Head Injuries**	☐	☐	**Radiation Treatment**	☐	☐
Arthritis	☐	☐	**Heart Disease**	☐	☐	**Respiratory Problems**	☐	☐
Artificial Joints	☐	☐	**Heart Valve Replacement**	☐	☐	**Rheumatic Fever**	☐	☐
Asthma	☐	☐	**Hemophilia**	☐	☐	**Severe Headaches**	☐	☐
Blood Disease	☐	☐	**Hepatitis – A, B or C**	☐	☐	**Sexually Transmitted Disease**	☐	☐
Cancer	☐	☐	**Herpes/Fever Blisters**	☐	☐	**Sickle Cell Disease**	☐	☐
Diabetes	☐	☐	**High Blood Pressure**	☐	☐	**Sinus Problems**	☐	☐
Dizziness/fainting spells	☐	☐	**HIV+/AIDS**	☐	☐	**Stroke**	☐	☐
Emphysema	☐	☐	**Kidney Problems**	☐	☐	**Thyroid Problems**	☐	☐
Epilepsy	☐	☐	**Liver Disease**	☐	☐	**Tuberculosis**	☐	☐
Glaucoma	☐	☐	**Low Blood Pressure**	☐	☐	**Ulcers**	☐	☐
Growths	☐	☐	**Nervous Disorders**	☐	☐			
Blood Transfusion			**Date:** _____			**Location:** _____		

Please tell us whom we may thank for referring you to our office or how you heard about us:

_____

CONSENT

I understand that the information provided here is complete and true to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my health status. I authorize Diablo Creek Dentistry and staff to perform any and all necessary dental diagnoses and treatment, with my informed consent.

_____ _____

Client Signature **Date**

If the patient is a minor, a parent or legal guardian must sign.

_____ _____ _____

Parent or Legal Guardian **Relationship to Client** **Date**

Warmest regards,

Dr. Elizabeth Mier, Dr. Keith Bradburn and team