Nathalie Tungesvik, DDS
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Patient Information

Patient Name _____
Last First Middle Initial Preferred name

Birth Date_____/_____/_____ **Social Security Number**_____

Family Status: Single____Married____Child____Other ____ **Gender:** Male ____ Female ____

Address_____
(Parent/guardian if Minor) Street Apt# City State Zip

Home Ph._____**Work Ph.**_____**Cell** _____
(Parent/guardian if Minor)

E-Mail Address_____
(Parent/guardian if Minor)

Employer _____ **Occupation** _____
(Parent/guardian employer if Minor)

Spouse's Name _____
(Parent/guardian if Minor) Last First Middle Initial

IS AN IMMEDIATE FAMILY MEMBER A PATIENT HERE? Name: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Emergency Contact_____
Name Relationship to Patient Phone

Dental Insurance Information

Name of Insured_____ **Relationship to patient**_____

Social Security Number _____ **Birth Date**_____/_____/_____

Name of employer_____ Work Phone_____ Ext._____

Employer Address_____
Street City State Zip

Insurance Company_____Group #_____Policy/ID #_____

Ins. Co. Address_____
Street City State Zip

We will need a copy of your insurance card at your initial appointment. Please bring your insurance card with you for each appointment.

*****Authorization and Release*****

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. Finance charge or interest of 1.5% a month will be applied to all balances over 90 days past due.
As a service to our clients, we provide a courtesy appointment reminder email and possibly other important emails that may be sent. By providing your email address, you consent to receiving such notifications.

X_____
Signature of patient (or parent/guardian if minor) Date

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 reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver,_____)		
☐ latex		
☐ 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 a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, 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 disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries_____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, 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 (i.e. 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, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. FEMALE - taking birth control pills_____	☐	☐
57. FEMALE - pregnant _____	☐	☐
58. MALE - prostate disorders_____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development 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

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 _____

ASA_____(1-6)

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? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
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 had any 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? _____	☐	☐

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 recession? _____	☐	☐
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 too 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 avoid brushing any part of your mouth? _____	☐	☐
18.	Do you have grooves 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 teeth together? _____	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26.	Are your teeth developing spaces or becoming looser? _____	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____	☐	☐
28.	Do you place your tongue between your teeth 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 your teeth in the daytime or make them sore? _____	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), 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 appearance of your teeth that you would like to change? _____	☐	☐
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 previous dental work? _____	☐	☐

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____