Cain Dental
2040 Castaic Lane Knoxville, TN 37932
865-246-0460 or 865-246-0745

Today's date:

First Name: _____ MI: _____ Last Name:_____

Date of birth: _____ Sex: __Male __Female **Family Status:** __Single __Married __Child __Other

Social security number: _____ Driver's license number: _____

Email: _____ Nickname:_____

HOME ADDRESS:_____

PHONE NUMBERS *Please check preferred contact number* Best time to call: _____

___ Home: _____ ___Work: _____ ___ Cell: _____

EMPLOYER INFORMATION

Name: _____ Address: _____ Phone: _____

Whom should we contact in an emergency? *(Please give phone # and relationship to you)*

_____

Whom are we allowed to speak to about your dental health? *(Besides you, parent, guardian, insurance)*

_____

Whom may we thank for referring you? _____

PREFERENCES _____No phone calls _____No correspondence ___No texts ___ No emails

PARENT OR GUARDIAN INFORMATION (if applicable)

Name: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (if not patient)

Person financially responsible for account: _____ Phone:_____

Relationship to patient: _____ SSN: _____ Date of Birth: _____

Home address: _____

Employment Information

Name: _____ Address: _____ Phone: _____

DENTAL INSURANCE

Policy Holder: _____ Patient ___ Responsible Party

If Policy holder is not the patient or responsible party, please input the policy holder's information.

Policy holder's full name:_____

Phone: _____ Date of birth: _____ SSN: _____

Address: _____

Employer's name: _____ Phone: _____

Address (if different from above): _____

Insurance company information

Insurance company name: _____ Phone number: _____

Address: _____

Insurance plan name: _____Insurance ID number: _____

Group ID number: _____ Union or local name: _____

SECONDARY INSURANCE *(If applicable)*

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Policy Holder: _____ Patient ___ Responsible Party ___ Policy holder of Dental Insurance

If Policy holder is not the patient or responsible party, please input the policy holder's information.

Secondary Policyholder's full name: _____

Phone number: _____ Date of birth: _____ SSN: _____

Address: _____

***Secondary* Policyholder's Employment Information**

Employer's name: _____ Phone: _____

Address: _____

***Secondary* Insurance company information**

Insurance company name: _____ Phone: _____

Address: _____

Insurance plan name: _____ Insurance ID number: _____

Group ID number: _____ Union or local name: _____

MEDICAL HISTORY

If you are completing this form for another person, please tell us your relationship: _____

If you are completing this for the patient, are you the legal guardian? ___Yes ___No

Your name *(if you are not the patient)*:_____ Phone: _____

Physician's Name: _____ *Phone number:* _____

Other physicians: _____

Approximate Date of last physical examination: _____ Height: _____ Weight: _____

Please list any conditions of illnesses for which you are currently being treated:_____

_____

If treated in a hospital or emergency room within the past two years, please describe:_____

_____

PLEASE CHECK EACH BOX FOR ANY HEALTH CONDITIONS YOU HAVE

By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ ADHD	☐ Ear problems (chronic)	☐ Psychiatric problems
☐ Anemia	☐ Eating or feeding disorder	☐ Sexually transmitted disease
☐ Auto-immune disease	☐ Genetic disorder	☐ Sinus problems (chronic)
☐ Arthritis (osteo, rheumatoid, lupus, fibromyalgia)	☐ Heart problems	☐ Seizure disorder (epilepsy)
☐ Adrenal gland disorder	☐ Hepatitis/liver problems	☐ Sleep apnea
☐ Bleeding disorder	☐ HIV/AIDS	☐Stomach/gastrointestinal disorder

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☐ Blood pressure problems	☐ Hormone problem (ex. menstrual, sex, puberty)	☐Transplant - organ or stem cell
☐ Brain/nerve disorder (ex. MR, Alzh, Autism, MS,CP)	☐ Joint replacement with a prosthesis	☐Tuberculosis
☐Cancer	☐ Kidney/bladder disorder	☐Thyroid gland disorder
☐ Diabetes	☐ Lung (ex. asthma, emphysema, cystic fibrosis)	☐Vision problems (ex. blindness, Glaucoma)
☐ Disability (from birth or acquired since birth)	☐ Osteoporosis	

If there are any other medical conditions we should be aware of, please describe:_____

_____

If you have a condition that could be spread by coughing, please describe:_____

_____

Allergy history:

☐ Dental restorative materials	☐ Food allergies	☐ Medication Allergy
☐ Latex allergy	☐ Seasonal of environmental	

Please select if you are allergic to any of these medications:

__ Penicillin __ Iodine Dye __ Codeine __ Latex __ Sulfa __ Aspirin

Please list any other allergies: _____

Please list any previous surgeries you have had with approximate dates *(i.e. back surgery, gall bladder, tonsillectomy, prosthetic joint replacement, etc.)*: _____

_____

Do you consume alcohol? ___None ___Social use ___More than social use

Do you use street drugs? ___None ___Marijuana ___Cocaine ___Methamphetamine ___Heroin ___Other

Do you use tobacco products? _____None _____Cigarette _____Cigar _____Smokeless _____Pipe

For children – Are immunizations up to date? ___Yes ___No ___Uncertain ___ Delayed immunization schedule

For women – Are you pregnant or think you may be pregnant? ___ Yes ___ No

Are you taking birth control pills? ___ Yes ___ No

Are you nursing? ___ Yes ___ No

Preferred pharmacy name and telephone number: _____

Do you take prescribed or over-the-counter medications on a regular basis? _____No _____Yes.

If yes, please List all of them - _____

_____

_____

Do you take Herbals/other remedies? __ No __Yes *If yes, please List all* - _____

_____

Please list any vitamins you take regularly:_____

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Do you take the blood thinning medication Coumadin? _____No _____Yes

Do you take any of these anticoagulants? __Aspirin __Plavix __Eliquis ___Xarelto ___ Pradaxa

Do you take Steroid Medication? ___No ___Yes

Do you take drugs with suppress the immune system? ___ No ___ Yes

Have you ever taken Bisphosphonates for osteoporosis or for chemotherapy for multiple myeloma? ___ No ___ Yes

DENTAL HISTORY

How can we help you today? _____

Do you have any tooth or oral pain? ___No ___Yes *If yes, where is the pain?*_____

Are you taking pain medication for oral pain? ___ No ___ Yes ___Uncertain

If yes, what pain medication? _____

Are you currently taking any antibiotics for oral infection? ___ No ___ Yes ___Uncertain

*If yes, which antibiotic?*_____

Please Check any which may apply:

☐ Bad breath	☐ Broken teeth	☐ Gum problems	☐Smile/cosmetic issues
☐ Bite problems	☐ Cavity problems	☐ Missing teeth	☐Old fillings which should be evaluated
☐ Broken fillings	☐ Chewing problems		

ORAL CARE HABITS

How often do you see a dentist for routine care?

☐ Annually	☐ Twice a year	☐ 3 or 4 times a year
☐ Only for pain	☐ Seldom	☐ Never

How many cavities have you had recently?:

☐ None	☐ Three or more during the last three years
☐ 2 or less in the past three years	☐ Uncertain

When was your last dental treatment? _____

What was done at that visit?

☐ Cleaning	☐ Denture/Partial	☐ Extraction	☐ Root canal
☐ Filling/Crown/Bridge	☐ Evaluation	☐ Gum treatment	☐Uncertain

When were your last dental x-rays taken? _____

Have you lost any teeth besides your baby teeth? _____No _____Yes

Please check below the reason for loss if applicable:

☐ Wisdom teeth extracted	☐ Extracted because of gum problem	☐ From an accident
☐ Extracted because of decay	☐ For orthodontic care	☐ Reason not listed

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How is your family's dental health?

☐ Most have good teeth	☐ History of dentures	☐ History of tooth loss
☐ Most have bad teeth	☐ History of gum disease	☐ Uncertain

What are you brushing habits?

☐ Once per day	☐ Three times per day	☐ Never
☐ Twice per day	☐ Seldom	☐ Not applicable

What type of toothbrush do you use?

__Hard __Medium __Soft ____ Sonicare ___Electric/Rotary __Uncertain __Not applicable

How many times per day do you eat or drink sugar containing items?

__Less than 3 times __More than 3 times __More than 5 times __None

Is the water at your home fluoridated? __Yes __ No __ Uncertain

Do you floss your teeth? __Daily __Weekly __Occasionally __ Seldom __Never __ Not applicable

Do you use other oral cleaning products? __WaterPik __Mouth rinse __Toothpick __Not applicable

Does your mouth feel dry most of the time? __ No __ Yes __ Not applicable

If so, is your dry mouth a new experience? __ No __ Yes __ Not applicable

What is the severity of your dry mouth? __ Mild __ Moderate __ Severe

Have you experienced any alteration in your taste perception? ___No ___Yes

Are there physical or mental limitations preventing oral hygiene? ___No __Yes

PERIODONTAL (GUM) HEALTH

Does food get stuck between your teeth? __No __Yes, a few places __Yes, in many places __Not applicable

Do your gums ever bleed when brushing your teeth? __No __Occasionally __Yes __Not Applicable

Are any of your teeth loose? __No __Yes *If yes, where?*_____

Are you concerned about receding gums? __ No __ *Yes If yes, were?*_____

CHEWING ABILITY

Can you chew your food well? __Yes __Not Very Well __No __Not applicable

Can you chew hard food comfortably? ___Yes __No

Do you have partials or dentures? __No __Yes

If you do have them, do they work well? __Yes __Not very well __No

Are your teeth very sensitive to hot or cold? __ No __Yes __ Sometimes __ Not applicable

Do you have any aches or pains in your jaws or ears? __No __Yes

Do you have any jaw clicking or popping? __No __Yes

Are you aware of any habit of grinding or clenching? __No __Yes

Are you interested in replacing lost teeth? __No __Yes __Uncertain

SMILE

Do you like your smile? __Yes __No __Would like whiter teeth __Would like to talk about smile __Uncertain

PAST DENTAL CARE

Have you ever had trouble with a previous dental treatment? _____No _____Yes

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If yes, please describe: _____

Previous dentist: _____ City:_____ State: ____ Phone: _____

Why are you changing? _____

Have you ever had root canal treatment? _____No _____Yes _____Uncertain

Have you ever had Periodontal (gum) treatment? - _____No _____Yes _____Uncertain

Have you ever had braces? _____No _____Yes _____Uncertain

Have you ever had your teeth ground or your bite adjusted? _____No _____Yes _____Uncertain

BREATH ODOR

Do you have a problem with bad breath odor? _____No _____Yes

DENTAL CARE ANXIETY *Please check any of the following that describe you.*

__Dental Care does not frighten me __A relaxation pill helps me with dental care __I am frightened of dental care

__Local anesthesia works well for me __I require IV sedation or general anesthesia __I have extreme dental phobia

__Nitrous Oxide (laughing gas) helps me tolerate dental care

OTHER MATTERS YOU WOULD LIKE TO TELL US ABOUT

Do you have other problems you would like to tell us about which have not been identified?

_____

If you are completing this form for a child please answer the following questions

Is this your child's first visit to the dentist? ___Yes ___No

If not, date and location of last dental care: _____

Has your child ever had a space maintainer, retainer, braces or any other dental tooth movement? _____

Was your child breast fed or bottle fed? _____Breast _____ Bottle _____Uncertain

Age discontinued - _____

Does your child have a past or current history of: ___Thumb sucking ___Finger sucking ___Pacifier

Do you want oral hygiene instructions given to your child? _____Yes _____No

School name: _____ Phone: _____ Grade: _____