Gunbarrel Dental Center
Rachel T. Barone, DDS, FAGD, FICOI
5400 Mt. Meeker Road
Boulder, CO 80301
Phone 303-530-4145 Fax 303-530-9620

PATIENT INFORMATION

Date _____

Patient Name _____
Last First Middle

Address _____
Street City State Zip Code

Gender Preference _____ Preferred Pronoun _____

Birthday _____ SS# _____

Cell Phone _____ Home Phone _____ Work Phone _____

_____
E-mail address (for confirmation of appointments & recall reminders)

If a child, give parent or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information (if other than yourself)

Name _____
Last First Middle

Address _____
Street City State Zip Code

Cell Phone _____ Home Phone _____ Work Phone _____

Marital Status _____ Birthday _____ SS# _____

Spouse's Name _____

Emergency Notification Information

In case of emergency, who should be notified?

Name _____ Phone _____

Relationship _____

DENTAL QUESTIONNAIRE

Last First Middle

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your needs. Your answers are for our records only and will be considered confidential.

Are you having any discomfort at this time? ☐ Yes ☐ No

Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely ☐ No

Date of your last visit: _____

Have you ever been treated for periodontal disease? (Gum disease, pyorrhea, trench mouth) ☐ Yes ☐ No

How often do you brush?_____ Brush is: ☐ Soft ☐ Medium ☐ Hard

Do you have or ever had any of the following:

MOUTH			TEETH		
Bleeding, sore gums	☐ Yes	☐ No	Loose teeth	☐ Yes	☐ No
Unpleasant taste / bad breath	☐ Yes	☐ No	Sensitive to hot	☐ Yes	☐ No
Burning tongue	☐ Yes	☐ No	Sensitive to cold	☐ Yes	☐ No
Frequent blister lips/mouth	☐ Yes	☐ No	Sensitive to sweet	☐ Yes	☐ No
Swelling/Lumps in mouth	☐ Yes	☐ No	Sensitive to biting	☐ Yes	☐ No
Ortho treatment (braces)	☐ Yes	☐ No	Food impaction	☐ Yes	☐ No
Biting cheeks/lips	☐ Yes	☐ No	Clenching/grinding	☐ Yes	☐ No
Clicking/popping jaw	☐ Yes	☐ No	If so when?	_____	
Difficulty opening or closing jaw	☐ Yes	☐ No	Shifting in bite	☐ Yes	☐ No
			Change in bite	☐ Yes	☐ No

Do you do the following?

Brush	☐ Yes	☐ No	Floss	☐ Yes	☐ No
Fluoride rinse	☐ Yes	☐ No	Other	_____	

Do you smoke?	☐ Yes	☐ No	Chew tobacco	☐ Yes	☐ No
Do you consume soft drinks often?	☐ Yes	☐ No	Is yes, how many servings per day?	_____	

The most important thing about my dental health is: _____

What do you fear most about dental care? _____

Check appropriate letter:

1. My mouth is:
   a) very comfortable
   b) moderately comfortable
   c) uncomfortable
2. a) I think the appearance of my mouth is great
   b) I'm satisfied with the appearance of my mouth
   c) I'm dissatisfied with the appearance of my mouth
3. a) I will do anything to keep my natural teeth
   b) I want to keep my natural teeth, but I only have a certain budget of time and money to spent on them.
4. a) I have set goals for my oral health with a previous dentist
   b) I want to set goals concerning my dental health
5. a) I have always done the best that was recommended for my health
   b) I have not done what dentist have recommended to me
   c) I rarely go to the dentist and I don't care abut having dental work done
6. a) I have put dentistry high on my priority list
   b) I put dentistry low on my priority list
   c) Dentistry is on my list but it's hard to find

I think that my present state of dental health is: ☐☐ Excellent ☐☐ Good ☐ Poor

Do you have any questions about dentistry and oral health that you never had adequately answered?

MEDICAL QUESTIONNAIRE

Name: _____ **Date:** _____

Complete answers to the following questions will allow your dentist to treat you on a more individual basis.
Indicate which of the following you have had or have at present:

ALLERGIES :

Penicillin	Yes	No	Codeine	Yes	No
Local Anesthetic	Yes	No	Latex	Yes	No
Metal / Jewelry	Yes	No	Other	_____	

AIDS	Yes	No	Anemia	Yes	No	Asthma	Yes	No
Blood Disease	Yes	No	Cancer	Yes	No	Diabetes	Yes	No
Epilepsy	Yes	No	Heart Disease	Yes	No	Heart Murmur	Yes	No
Hay Fever	Yes	No	High Blood Pressure	Yes	No	Low Blood Pressure	Yes	No
Hepatitis	Yes	No	Pacemaker	Yes	No	Rheumatic Fever	Yes	No
Stroke	Yes	No	Tuberculosis	Yes	No	Tumor	Yes	No
Ulcers	Yes	No	Venereal Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Hypoglycemia	Yes	No	Aspirin Sensitivity	Yes	No	Iodine Sensitivity	Yes	No
Emphysema	Yes	No	Heart Surgery	Yes	No	Breathing Problems	Yes	No
Acid reflux	Yes	No	Frequent Indigestion	Yes	No	Sleep Disorder	Yes	No
			Bacterial Endocarditis	Yes	No	Joint Replacement	Yes	No

Has your doctor told you to take antibiotics prior to dental work? Yes No
Have you ever used any tobacco products? Yes No
Do you suffer from lack of sleep? Yes No
Do you snore? Yes No
Are you taking any medication? Include vitamins and herbs. Yes No
If yes, what? _____
How much alcohol do you consume per week? _____
Name of primary care physician: _____ **Phone:** _____
Do we have your permission to contact your physician with information about your oral health?
Yes_____No_____
If you are being treated for cancer or osteoporosis, please circle any of the following drugs that you are receiving:
a.Aredia b.Zometa c.Bonefos d.Loron e.Bondranat.
Who is your physician that monitors these drugs for you?
Name _____ Phone_____
Do we have your permission to speak to your physician regarding these particular medications?
Yes_____ No_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature:_____ Date _____

UPDATES:

Date: _____