NEW PATIENT INFORMATION & CONSENT

Dental and Hygiene History

1. We would like to take some time get to know you and learn a bit about your dental history.
   Who was your previous dentist/dental office? _____
   _____
   When was your last complete dental exam? _____
   Did you have X-rays taken? _____
2. Is your teeth's appearance (color, shape, alignment) something that you are concerned with? Y/N
   _____
3. How frequently do you have your dental exams? _____
4. Have you previously had a significant amount of dental work completed? Y/N
   If yes, please provide details: _____
   _____
5. What has brought you in today as compared to 3 months ago or 3 months from now?
   _____
   _____
6. Are you aware of any loose teeth? Y/N _____
7. Do you have any TMJ (jaw joint) concerns? Grind/Clench Y/N

   When opening your jaw do you hear ____ a click? ____ a pop? ____ grating noises?

   Do you get headaches or migraines? Y/N
8. Do you breathe through your nose or mouth? Nose Mouth
9. Have you ever been given oral hygiene instructions? ___Brushing ___Flossing____Other
10. Are your teeth sensitive to ; ____ Cold, _____ Hot, ____ Sweets, _____other
11. Do your gums bleed when: ___Brushing ___Flossing ___Spontaneously
12. Do your gums feel tender or swollen? ___Yes ___No
13. Does food catch between your teeth? ___Yes ___No

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is a scale intended to measure daytime sleepiness. This can be helpful in diagnosing sleep disorders such as sleep apnea.

Scale	**Situation**	**Score**
0= Would never doze/sleep	Sitting & Reading	_____
1=Slight chance of dozing/sleeping	Watching TV	_____
2=moderate chance of dozing/sleeping	Sitting in active in a public place	_____
3= High chance of dozing/sleeping	Lying down in the afternoon	_____
	Sitting quietly after lunch (No alcohol)	_____
	Stopped in traffic for a few minutes While driving	_____
	Being a passenger in a vehicle for an Hour or more	_____

PATIENT CERTIFICATION, APPROVAL & CONSENT

I, the undersigned, certify that all medical and dental information provided to the office of Eguren Dentistry is true to my knowledge and I have not omitted any pertinent information. I, the undersigned, consent to the performing of dental and oral surgery procedures **agreed** to be necessary or advisable, including the use of local anaesthetic as indicated. I will assume responsibility for fees associated with these procedures.

Patients (Parent/Guardian) signature _____Date_____