



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



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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.

<u>Scale</u>	<u>Situation</u>	<u>Score</u>
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 _____