Platte Canyon Dental
5950 S Platte Canyon Rd
Ste D9
Littleton, CO 80123
Ph # : 303-797-2286
Fax # : 303-797-2287

PLATTE CANYON DENTAL

Patient Personal Information

Title		Preferred Name		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Emergency Contact		Emergency Phone #	
Email				Student		SSN	
Health Care Guardian Name				School Name			
Health Care Guardian Phone #				Referral Type			

Person responsible/guarantor for paying bills

Title		Preferred Name		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic or Bad Reaction:

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Ibuprofen
- ☐ Y ☐ N Acetaminophen (Tylenol)
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Tetracycline
- ☐ Y ☐ N Fluoride
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex
- ☐ Y ☐ N Milk
- ☐ Y ☐ N Fruit
- ☐ Y ☐ N Nuts
- ☐ Y ☐ N Red dye
- ☐ Y ☐ N Local Anesthetics

- ☐ Y ☐ N Hospitalization for injury
- ☐ Y ☐ N Heart problems: Heart attack
- ☐ Y ☐ N Heart problem: Cardiac Stent
- ☐ Y ☐ N Infective endocarditis
- ☐ Y ☐ N Artificial heart valve
- ☐ Y ☐ N Repaired heart defect (PFO)
- ☐ Y ☐ N Pacemaker or Defibrillator
- ☐ Y ☐ N Orthopedic joint replacement
- ☐ Y ☐ N Heart murmur
- ☐ Y ☐ N Rheumatic or Scarlet Fever
- ☐ Y ☐ N High or Low Blood pressure

- ☐ Y ☐ N Sinus Congestion
- ☐ Y ☐ N Sleep problems (eg snoring)
- ☐ Y ☐ N Kidney disease
- ☐ Y ☐ N Liver disease or jaundice
- ☐ Y ☐ N Vertigo (eg room is spinning)
- ☐ Y ☐ N Thyroid, parathyroid disease
- ☐ Y ☐ N Calcium deficiency
- ☐ Y ☐ N Hormone deficiency/imbalance
- ☐ Y ☐ N High cholesterol
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Stomach or duodenal ulcer
- ☐ Y ☐ N Eating Disorder (eg bulimia)

- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Contact lenses
- ☐ Y ☐ N Head or neck injuries
- ☐ Y ☐ N Epilepsy, convulsions/seizures
- ☐ Y ☐ N Alzheimer's disease/Dementia
- ☐ Y ☐ N Viral infections (cold sores)
- ☐ Y ☐ N Lumps or swelling in the mouth
- ☐ Y ☐ N Hives, skin rash, hay fever
- ☐ Y ☐ N STI/STD/HPV
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N HIV/AIDS
- ☐ Y ☐ N Tumor, anormal growth
- ☐ Y ☐ N Radiation therapy

☐ Y ☐ N Metals (nickel, gold, other)
☐ Y ☐ N Sulfa
☐ Y ☐ N Other

DO YOU HAVE/HAVE YOU EVER HAD:

☐ Y ☐ N Hospitalization for illness
☐ Y ☐ N A Stroke (take blood thinners)
☐ Y ☐ N Anemia or other blood disorder
☐ Y ☐ N Prolonged bleeding (INR > 3.5)
☐ Y ☐ N Pneumonia
☐ Y ☐ N Emphysema, shortness of breath
☐ Y ☐ N Sarcoidosis
☐ Y ☐ N Chronic Ear Infections
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Measles
☐ Y ☐ N Breathing Problems (eg asthma)
☐ Y ☐ N Gastric Reflux/Acid Reflux
☐ Y ☐ N Celiac Disease
☐ Y ☐ N Crohn's disease
☐ Y ☐ N Inflammatory bowel disease
☐ Y ☐ N Osteopenia/Osteoperosis
☐ Y ☐ N Taken Bisphosphonates
☐ Y ☐ N Arthritis or gout
☐ Y ☐ N Rheumatoid Arthritis
☐ Y ☐ N Autoimmune disease
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Difficulty managing stress
☐ Y ☐ N Psychiatric treatment
☐ Y ☐ N Antidepressants
☐ Y ☐ N Mood stabilizing medications
☐ Y ☐ N ADD/ADHD
☐ Y ☐ N Alcohol Use
☐ Y ☐ N Recreational drug use

Additional Comments

Dental Questionnaire

DENTAL HISTORY

How would you rate the condition of your mouth? Excellent, Good, Fair, or Poor? _____

Previous Dentist _____

Date of most recent dental exam _____

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? _____

PERSONAL HISTORY

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Have you had an unfavorable dental experience? _____

Have you ever had complications from past dental treatment? _____

Have you ever had trouble getting numb or had any reactions to local anesthetic? _____

Did you ever have braces, orthodontic treatment or had your bite adjusted? _____

Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury? _____

GUM AND BONE

Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____

Have you ever had, or been told, you have gum loss, gum disease, or bone loss between your teeth? _____

Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____

Is there anyone with a history of periodontal disease in your family? _____

Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____

Have you ever had any teeth become loose (without an injury) or feel them move when chewing? _____

Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____

TOOTH STRUCTURE

Have you had any cavities within the past 3 years? _____

Does the amount of your saliva seem too little or do you have difficulty swallowing or eating food? _____

Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth? _____

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing parts of your mouth? _____

Do you have grooves or notches on your teeth near the gum line? _____

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____

Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

Does your jaw joint ever have pain, sounds (popping/cracking), or limited opening or locking? _____

Do you feel like you need to pull your lower jaw back or it is being pushed back when biting? _____

Do you avoid or have trouble chewing gum, raw carrots, nuts, bagels, or other hard, dry foods? _____

In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or bite changed? _____

Are your teeth becoming more crooked, crowded, or overlapped? _____

Are your teeth developing spaces or becoming more loose? _____

Do you have more than one bite, or need to squeeze/tap, shift your jaw to make teeth fit together? _____

Do you place your tongue between your teeth or close your teeth against your tongue? _____

Do you chew ice, bite your nails, use your teeth to hold objects, or have other oral habits? _____

Do you clench or grind your teeth in the daytime/nighttime or ever make them sore? _____

Do you have any problems with sleep, wake up with a headache or an awareness of your teeth? _____

Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

Is there anything about the appearance of your mouth (smile, teeth, gums) you would like to change? _____

Have you ever bleached (whitened) your teeth? _____

Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____

Have you been disappointed with the appearance of previous dental work? _____

Medical Questionnaire

MEDICAL HISTORY

Name of Physician/and their specialty _____

Most recent physical examination _____

Purpose of most recent physical examination _____

What is your estimate of your general health? Excellent? Good? Fair? Poor? _____

Emergency Contact

Emergency Contact Name	
Emergency Contact Phone	
Emergency Contact Relationship to Patient	
ARE YOU:	
Presently being treated for any other illness	
Aware of a change in your health in the last 24 hours (eg fever, chills, new cough, or diarrhea)	
Taking medication for weight management	
Taking dietary supplements, vitamins, and/or probiotics	
Often exhausted or fatigued	
Experiencing frequent headaches or chronic pain	
A smoker, smoked previously or other (eg smokeless tobacco, vaping, e-cigarettes, and cannabis)	
Considered a touchy/sensitive person	
Often unhappy or depressed	
Taking birth control pills	
Currently pregnant or breast feeding	
Diagnosed with a prostate disorder	
OTHER	
Describe any medical treatment or impending surgery that may affect your dental treatment.	
List all medications, supplements, vitamins taken with the last two years	
PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY TAKE	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**