CENTER FOR
ADVANCED DENTISTRY
KENT E. WHITE DDS

Please Help Us Understand You

Patient Name: _____ Date_____

Our office is different in that we give our patients our full attention. We schedule one patient at a time, find out what is important to them and then deliver what we promise. Please answer the following so we can understand you better. Thank you!

In your own words, how can we help you?

_____

_____

_____

Are you looking for a new dental home? ___ yes ___no

Do you plan on returning to your old dentist after your treatment is complete? ___yes ___no

I am interested in:

___ Nonsurgical Facelift ___ TMJ Treatment ___Implants ___Smile Makeover

___ FOY™ Dentures ___ Filling Upgrade ___Sedation Dentistry

What is your time frame for the above? _____

Your first visit to our office is designed to answer any of your questions, which allows you to see if we are the right Dentist for you. If you feel we are not the best Dentist for you, we will be happy to refer you to who we know is a good match for you. If you feel we can help you, we will take records, do a thorough examination and give you specific options for your dental treatment.

Please begin thinking about the following:

How important are the following concepts: dental health, prevention, dental cosmetics, and facial cosmetics?

We will be discussing this with you shortly.

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Patient Name _____ Address w/Zip_____

Employer_____ Work Phone # _____

Home Phone # _____ Cell Phone # _____

Email _____ SSN _____

Primary Physician's Name_____ Physician Phone# _____

Date of Last Physical _____ Date of Birth_____

Spouse Name_____ Contact Phone #_____

Emergency Contact_____ Contact Phone #_____

Place a mark on "yes" or "no" to

AIDS/HIV	❑Yes	❑No	Heart Lesions	❑Yes	❑No	Tonsillitis	❑Yes	❑No
ANEMIA	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Arthritis, Rheumatism	❑Yes	❑No	Heart Problems	❑Yes	❑No	Tumor or growth on		
Artificial Heart Valves	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Head/Neck	❑Yes	❑No
Artificial Joints	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Ulcer	❑Yes	❑No
Asthma	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Bleeding abnormally,	❑Yes	❑No	Liver Disease	❑Yes	❑No	Headaches	❑Yes	❑No
with extractions or surgery			Mitral Valve Prolapse	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Blood Disease	❑Yes	❑No	Nervous Problems	❑Yes	❑No	Jaw Popping	❑Yes	❑No
Cancer	❑Yes	❑No	Pacemaker	❑Yes	❑No	Limited Opening	❑Yes	❑No
Chemical Dependency	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Congested Ears	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Dizziness	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Posture Problems	❑Yes	❑No
Cough, persistent	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Clenching	❑Yes	❑No
Diabetes	❑Yes	❑No	Stroke	❑Yes	❑No	Grinding	❑Yes	❑No
Epilepsy	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Facial Pain	❑Yes	❑No
Fainting or dizziness	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No	Neck Ache	❑Yes	❑No
Glaucoma	❑Yes	❑No	Thyroid Problems	❑Yes	❑No	Bell's palsy	❑Yes	❑No

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

_____

_____

Are you allergic to any medications or other substances?

_____

_____

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

____yes ____no List Medication _____

Circle if you have seen: an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery

Circle if you have seen any of the following healthcare professionals: ENT, Neurologist, Chiropractor, or Massage Therapist.

Do you snore, use a CPAP or had a sleep study?

_____yes _____no

Have you ever had radiation to the head and/or neck?

_____ yes _____ no

Do you use tobacco products? _____yes _____no

Signature: _____ Date: _____

Revised 01/2014