Dr. Maria - Astrid Urrutia

DENTAL HISTORY

Previous Dentist _____ Specialty _____

_____ _____
Address Area Code Telephone

Period of Treatment _____
Date

Other Dentist _____ Specialty _____

_____ _____
Address Area Code Telephone

Period of Treatment _____
Date

Date of last dental visit _____ Date of last full-mouth X-ray _____

Date of last complete dental examination _____

Do you have any of your previous dental records or X-rays? _____

What is your immediate dental concern? _____

Please circle YES or NO. If YES, please fill in details.

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavourable reaction to dentistry - fainting or allergic reaction?
What? _____

Yes No Have you ever bled excessively following dental treatment? _____

Have you lost any teeth? From what cause? _____

Have you had any of the following?

- ❑ bridges
- ❑ partial dentures
- ❑ full dentures
- ❑ root canal treatment
- ❑ gum treatments
- ❑ abscessed teeth
- ❑ teeth extracted
- ❑ orthodontic braces
- ❑ oral cysts or tumors

Yes No Do you have any growths, swelling or sores in your mouth? How long have they existed? _____

Yes No Do you have any difficulty in swallowing? _____

Yes No Do your gums bleed when brushing your teeth? _____

Yes No Do you avoid brushing any part of your mouth? Why? _____

Yes No Have you ever been told you have gum disease? When? _____

Yes No Is any part of your mouth sensitive to hot, cold, pressure, or sweet? _____

Yes No Do you have a burning sensation of your mouth? _____

Yes No Have you ever had a bad reaction to a dental anesthetic? _____

Yes No Does food catch between your teeth? _____

Yes No Do you have any pain or soreness around your eyes or ears or other parts of your face? _____
When? _____

Yes No Are you aware of stiff neck muscles? How often? _____

Yes No Do you ever awaken with an awareness of your teeth or jaws? How often? _____

Yes No Are you aware of clenching your teeth during your daytime hours? How often? _____

Yes No Have you ever been told you grind your teeth during sleep? How often? _____

Yes No Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

Yes No Do you have difficulty in opening your mouth widely? _____

Yes No Do you have "tension" headaches? How often? _____

Yes No Do you have an unpleasant taste or odour in your mouth? _____

Yes No Do any members of your family including your parents wear dentures? _____

Yes No Are you deeply concerned about the finances required to return your mouth to excellent dental condition? _____

Yes No Do you get frustrated because you always have something to be treated or repaired when you visit your dentist? _____

Yes No Do you like the appearance, colour and alignment of your teeth? _____

Yes No Would you like to change the appearance of your teeth? _____

Yes No Do you have any other dental complaint? _____

DR. MARIA - ASTRID URRUTIA

MEDICAL HISTORY

Family Physician _____ Specialty _____

Address _____
Area Code Telephone

Additional Physician _____ Specialty _____

Height _____ Weight _____ Age _____ Date of last complete medical examination _____ Were blood studies performed? ❑ Yes ❑ No

Please circle YES or NO. If YES, please fill in details

Yes No Do you have a current medical problem? What? _____
Yes No Do you have heart trouble? What kind? _____
Yes No Have you had rheumatic fever? When? _____
Yes No Do you have high or low blood pressure? Is it controlled? _____
Yes No Have you had pains in the chest or shortness of breath? _____
Yes No Do your ankles ever swell? _____
Yes No Has your physician ever told you that you are anemic? _____
Yes No Have you ever had a stroke? When? _____
Yes No Have you ever had a seizure? When? _____
Yes No Have you ever had diabetes? How is it controlled? _____
Yes No Are you subject to fainting or dizziness? When? _____
Yes No Do you have headaches? How often? _____
Yes No Do you have problems with insomnia? How often? _____
Yes No Do you have any nervous disorder? How is it controlled? _____
Yes No Do you take tranquilizers or sedatives? How often? _____
Yes No Do you take aspirin? How often? _____
Yes No Are you allergic to medication? What? _____
Yes No Have you been advised not to take any medication? What? _____
Yes No Do you have asthma or hay fever? How is it controlled? _____
Yes No Have you ever had tuberculosis? When? _____
Yes No Have you ever had infectious hepatitis? When? _____
Yes No Do you have arthritis? How is it controlled? _____
Yes No Have you ever had a tumor or cancer? How was it treated? _____
Yes No Have you ever had any major operations? What kind? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Are you taking any medication or herbal supplements? Please list:

Taking _____ **For** _____ **Taking** _____ **For** _____
Taking _____ **For** _____ **Taking** _____ **For** _____
Taking _____ **For** _____ **Taking** _____ **For** _____
Taking _____ **For** _____ **Taking** _____ **For** _____

Yes No Do you wear contact lenses? _____
Yes No Do you become fatigued easily? At what time of day? _____
Yes No Have you ever been tested for HIV? _____
Yes No Do you frequently not eat breakfast? _____
Yes No Do you take more than one alcoholic drink per day? How many? _____
Yes No Do you use tobacco? How much? _____
Yes No Is your diet medically supervised? For what purpose? _____
Yes No Have you ever been told that you snore? _____
Yes No Do you ever stop breathing for short periods while sleeping? _____

...For Women

Yes No Are you pregnant? Expected delivery date _____
Yes No Have you reached menopause? If so, are you taking supportive medication? _____

Dr. Maria - Astrid Urrutia

GENERAL INFORMATION

❑ Dr. ❑ Mr. ❑ Ms. ❑ Mrs. ❑ Miss

Last First Middle

Day Month Year

Birthdates

Current Residence Address

Number Street City Postal Code

Telephone Number Cell Phone Number

Email

Employer Occupation

Name of Spouse Cell Phone of Spouse

Spouse's Occupation

Employer Phone Number

Emergency Contact:

Name Area Code Telephone Relationship

Number Street City Postal Code

If patient is a minor, who is legally responsible?

Name

Number Street City Postal Code Area Code Telephone

Person financially responsible Address

By whom were you referred? When?

CONSENT STATEMENT

This is to certify that I, the undersigned, (a) grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and other health practitioners, (b) consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated, and (c) will assume responsibility for fees associated with these procedures.

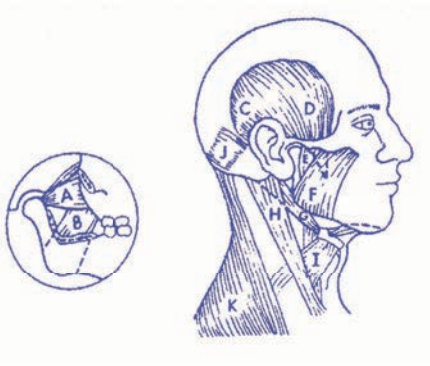
Date Signature

Relationship, if other than patient

Dr. Maria - Astrid Urrutia

TMJ SCREENING

DATE:								
Max. Opening								
Left Lateral								
Right Lateral								
	Right	Left	Right	Left	Right	Left	Right	Left
Lateral Capsule								
Lat. Pterygoid (A)								
Med. Pterygoid (B)								
Post. Temporal (C)								
Ant.Temporal (C)								
Deep Masseter (E)								
Super Masseter(F)								
Diagastric (G)								
SCM (H)								
Hyoid Area (I)								
Occipital Area (J)								
Trapezius (K)								



JOINT NOISES: _____

COMMENTS: _____

TMJ SCREENING

DATE:				
OB (mm)				
OJ (mm)				
Molar Class				
Canine Class				
Skeletal Class				
X-bites				
Midlines				
MxAL D/E				
MdAL D/E				

COMMENTS: _____

TREATMENT