ELEMENT DENTAL
by Nicholas Pile, DMD

Thank you for your interest in our dental practice. We are very grateful that you have decided to consult with us regarding your dental needs.

Your initial visit will be primarily concerned with the identification of your personal dental health desires and your present condition, in that regard, it is our intention to provide you with a superior evaluation of all aspects of function and esthetics. The evaluation will include appropriate imaging, photographs and models, as well as an opportunity to share with us your previous dental experiences and any of your thoughts and wishes regarding your dentistry. This comprehensive information will provide us with a basis for identifying solutions which appropriately address your reasons for visiting our practice and will assist us in being most effective in working with you according to your wishes.

To serve you in properly addressing your dental needs is a privilege for us, thank you sincerely for the opportunity. We look forward to seeing you soon.

We have included a multiple page questionnaire that will assist us in getting to know you better and in being fully prepared for your visit. While we would very much appreciate having this information prior to your visit, if you would prefer completing it in person with us, please bring it along and we'll complete it together.

Element Dental by Nicholas Pile, DMD
623.551.5555
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CONFIDENTIAL 1

Element Dental by Nicholas Pile, DMD

PERSONAL INFORMATION

Full Name _____ Today's Date _____
Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as _____ Social Security#_____ Birthdate _____

Whom may we thank for referring you to our practice? _____

Address _____ Home Phone _____

Address _____ Work Phone _____

City _____ State ____ Zip _____ Cell Phone _____

E-mail address _____

Preferred contact ❑E-mail ❑Home Phone ❑Work Phone ❑Cell Phone Best time to call _____

Employer _____ Occupation _____

Spouse / Partner _____ Cell Phone _____

Additional Emergency contact _____ Phone _____

Last dental visit _____ with Dr. _____

PLEASE SELECT ONE BOX ON EACH LINE

❑My mouth is very comfortable ❑My mouth is moderately comfortable ❑My mouth is uncomfortable

❑My smile is excellent ❑I would like to change my smile ❑I am unconcerned about my smile

❑I will do whatever I must to keep my teeth ❑I want to keep my teeth but only within a certain budget of time and money

❑I've done the dentistry recommended to me ❑I've NOT done dentistry recommended to me ❑Never been recommended

MY DENTAL HEALTH IS ❑Excellent ❑Good ❑Fair ❑Poor

Why have you made this appointment _____

Account name preference: ❑Self ❑Spouse
Payment preference: ❑Check ❑Credit card (Visa, MC, AMEX)

CONFIDENTIAL 2

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Physician _____ Phone _____

How would you assess your general health ❑Good ❑Fair ❑Poor Last physical _____

Have you been hospitalized in the last 3 years? ❑Yes ❑No _____

List medications you take - please include prescription and over-the-counter (Continue on other side if needed)

_____ _____ _____

_____ _____ _____

Do you now have or have you ever had the following?

❑YES ❑NO Severe or Frequent Headaches
❑YES ❑NO High Blood Pressure
❑YES ❑NO Heart Attack
❑YES ❑NO Heart Murmur
❑YES ❑NO Angina / Chest Pain
❑YES ❑NO Shortness of Breath
❑YES ❑NO Asthma
❑YES ❑NO Emphysema
❑YES ❑NO Scarlet Fever
❑YES ❑NO Rheumatic Fever
❑YES ❑NO Heart Surgery
❑YES ❑NO Pacemaker
❑YES ❑NO Mitral Valve Prolapse
❑YES ❑NO Congestive Heart Failure
❑YES ❑NO Swelling of the Ankles
❑YES ❑NO Hardening of the Arteries
❑YES ❑NO Abnormal Bleeding
❑YES ❑NO Frequent Nose Bleeds
❑YES ❑NO Blood Transfusion
❑YES ❑NO Fainting
❑YES ❑NO Stroke
❑YES ❑NO Hepatitis

❑YES ❑NO Kidney Disease
❑YES ❑NO Cancer
❑YES ❑NO Chemotherapy
❑YES ❑NO Radiation Treatment
❑YES ❑NO HIV / Aids
❑YES ❑NO Shingles
❑YES ❑NO Cold Sores / Fever Blisters
❑YES ❑NO Diabetes
❑YES ❑NO Tuberculosis
❑YES ❑NO Arthritis
❑YES ❑NO Artificial Joint
❑YES ❑NO Artificial Valve
❑YES ❑NO Sinus Truoble
❑YES ❑NO Epilepsy / Siezure
❑YES ❑NO Psychiatric Problems
❑YES ❑NO Depression
❑YES ❑NO Ulcers
❑YES ❑NO Colitis
❑YES ❑NO Anemia
❑YES ❑NO Venereal Disease
❑YES ❑NO Glaucoma
❑YES ❑NO Drug / Alcohol Dependence

_____ _____

_____ _____

_____ _____

_____ _____

CONFIDENTIAL 3

Element Dental by Nicholas Pile, DMD

Have you ever had an **ALLERGIC** reaction? ❑No ❑Yes If Yes please list allergies:
Include medications, substances, foods, etc.

_____ _____ _____

_____ _____ _____

Continue on other side if needed

Do you consider yourself under an abnormally high amount of stress? ❑Yes ❑No

Do you sleep well? ❑No ❑Yes

Have you ever smoked? ❑No ❑ I Quit When? _____ ❑Yes - Still do How much? _____

Have you ever chewed tobacco? ❑No ❑ I Quit When? _____ ❑Yes - Still do How much? _____

Do you exercise regularly? ❑No ❑Yes If YES what do you enjoy doing _____

WOMEN Are you taking birth control pills? ❑No ❑Yes

Are you pregnant? ❑No ❑Yes - Due date _____

Are you currently nursing? ❑No ❑Yes

The information present on these pages is true to the best of my knowledge. I authorize the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. Upon my verbal agreement following discussion of recommended treatment, I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I have read the above: Signature _____ Date _____

CONFIDENTIAL 4

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If your consultation visit is concerning TMJ or TMD concerns please complete the following:

I am experiencing:

❑Headaches ❑Neckaches ❑Shoulder Pain ❑Throat Pain
❑Back Pain ❑Ear Pain ❑Hearing changes ❑Ringing
Ears ❑Ear/Sinus Congestion ❑Ear/Sinus Pain ❑Visual Symptoms ❑Eye Pain ❑Muscle Spasms ❑Jaw Pain ❑Jaw noises ❑Jaw Locking ❑Fatigue ❑Difficulty Sleeping ❑Difficulty Eating
❑Dizziness ❑Swelling ❑Other
_____

Circumstances under which the problem began? _____

_____

Is the pain ❑Constant or ❑Intermittent (comes and goes) How often? _____
Is the pain worse in the ❑Morning ❑Afternoon ❑Always the same
Does it hurt to move your jaw? ❑Yes ❑No Does it hurt to bite firmly? ❑Yes ❑No
Does it hurt to chew? ❑Yes ❑No Does pain increase if you open wide ❑Yes ❑No

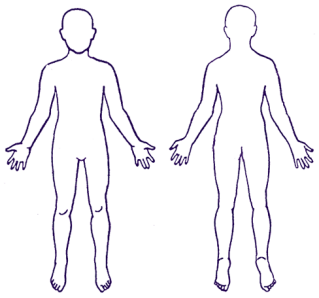
Describe the pain (what it feels like)_____

What makes it feel better? _____

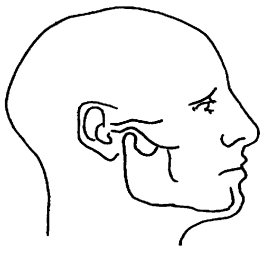
What makes it worse? _____

On these figures please outline where your pain is.

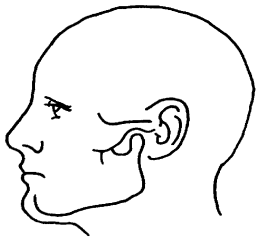
Front Back



Right Side



Left Side



Does your jaw make noise? ❑No ❑Not now but it used to
❑Yes When? _____

Has your jaw ever **locked open?** ❑No ❑Yes **locked closed?** ❑No ❑Yes

Do you clench ❑ or grind ❑ your teeth? ❑No ❑Yes – When? ❑Night ❑Day

Do you have sore or sensitive teeth? ❑No ❑Yes - Where? _____

Can you remember any injury to your jaw? ❑No ❑Yes

If Yes, describe _____

Have you ever had General Anesthesia (for surgery) ❑No ❑Yes …. When _____

If this injury is due to an accident is there (or will there be) a legal case involved? ❑No ❑Yes

Do you take medication for the pain? ❑No ❑Yes .. what _____

Do you take medication for relaxation? ❑No ❑Yes .. what _____

Have you had treatment for your pain? ❑No ❑Yes

If Yes, what kind? ❑Bite Splint ❑Medication ❑Physical Therapy
❑Surgery ❑Orthodontics
❑Counseling ❑Occlusal (Bite) Adjustment
❑Other _____

What else do you want the Doctor to know?