ARIZONA CENTER
FOR LASER DENTISTRY

Drs. Enrico & Roberto DiVito General, Cosmetic, Laser Dentistry Non-Surgical TMJ Management 7900 E. Thompson Peak Pkwy.
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Purpose of visit _____

Whom may we thank for referring you to our office? _____**Phone**_____

☐ **Dr.** ☐ **Mr.** ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** _____ _____ _____
Last First M.I.

Address _____ _____ _____ _____
Street City State Zip Code

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Birth Date _____ **Soc. Sec. No.** _____ **E-mail** _____

Responsible party if patient is a minor _____

Occupation _____ **Employer** _____ **No. of Years** _____

Business Address _____ _____ _____ _____
Street City State Zip Code

Name of Spouse _____ **Birth Date** _____ **Soc. Sec. No.** _____

Cell Phone _____ **Employer** _____**Work Phone** _____ **E-mail**_____

Landlord _____ **Phone** _____

Nearest relative not living with you _____ **Phone** _____ **E-mail**_____

Whom may we contact in case of an emergency _____ **Phone** _____

Name of Dental Insurance Co. _____ **Group #** _____

Subscriber's Name _____ **Medical Insurance Co.** _____

Payment is due on the day of treatment. Responsible party for payment _____

I will be paying today by ☐ **Cash** ☐ **Check** ☐ **Credit Card**

I understand and agree that (regardless of my insurance status) I am responsible for the entire balance of my account at the time professional services are rendered. If insurance covers the procedure, insurance reimbursements will then be paid directly to me. Any accounts not paid in full will carry a billing fee of $25.00 per month. If suit is instituted to collect this note or any portion thereof, I promise to pay such additional sums as the court may adjudge reasonable as attorney's fees in said suit. Demand, presentment as for payment, protest and notice of protest are hereby waived. If necessary, I authorize this office to make inquiries with Credit Reporting Agencies regarding m, or if a married person, my marital community including my spouse. I hereby waive any confidentiality associated therewith.

I have read all the information on this sheet and have completed the answers. I certify that this information is **true** and **correct** to the best of my knowledge. **I will notify you of any changes in my health status or the above information.**

Signature of Patient or Parent if patient is a minor _____ **Date** _____

MEDICAL HISTORY: Date of last examination _____

Name of Physician _____ City _____ Phone_____

Do you have a current medical problem? □ YES □ NO Explain _____

Do you smoke or use tobacco? □ YES □ NO How much? _____

Do you drink coffee or soda? □ YES □ NO How much? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

□ Arthritis, sore joints	□ Nervous breakdown	□ Heart Attack
□ Diabetes	□ Psychotherapy	□ High blood pressure
□ Stroke	□ Asthma/emphysema	□ Low blood pressure
□ Anemia/Leukemia	□ Shortness of breath	□ Pain, pressure, tightness in chest
□ Epilepsy, fainting spells	□ Swelling ankles/feet	□ X-ray, chemo/radiation therapy
□ Convulsions	□ Liver Disease	□ Alcohol or drug abuse
□ Headache	□ Hepatitis, jaundice	□ Other

ARE YOU NOW:

□ Pregnant	□ On a prescribed diet	□ Using thyroid pills
□ Using anticoagulants	□ Using anti-depressants	□ Blood Pressure Med

ARE YOU NOW TAKING OR USING MEDICATION FOR:

□ Diabetes (pills or shots)	□ Nerves (tranquilizers)	□ Arthritis or rheumatism
□ Stomach (ulcer, other)	□ Blood (liver/iron pills)	□ Allergies
□ Heart or blood pressure		

Are you taking prescription or recreational drugs? □ YES □ NO List _____

HAVE YOU EVER BEEN SICK FROM, SHOWN AN ALLERGY TO OR TOLD NOT TO TAKE:

□ Antibiotics	□ Codeine	□ Aspirin
□ Metals	□ Latex	□ Penicillin
□ Tetracycline	□ Sulfa drugs	□ Other
□ Novocain (or other dental anesthetic)		_____

Have you ever had a tumor or cancer? □ YES □ NO
Where?_____

Have you ever had a major operation? □ YES □ NO
What kind?_____

Have you ever been in a serious accident? □ YES □ NO
Describe _____

Following injuries, have you ever had bleeding problems? □ YES □ NO

Do injuries and cuts take longer to heal now than previously? □ YES □ NO

Have you recently lost weight unintentionally? □ YES □ NO

Is there a history of diabetes in your family? □ YES □ NO

DENTAL HISTORY: Date of last examination _____ Former Dentist _____

Have you come to this office for relief of pain?	☐ **YES**	☐ **NO**
Have you had the pain more than 3 weeks:	☐ **YES**	☐ **NO**
Do your gums bleed when brushing your teeth?	☐ **YES**	☐ **NO**
Do you floss? If so, how often _____	☐ **YES**	☐ **NO**
Have you ever been diagnosed with pyorrhea?	☐ **YES**	☐ **NO**
Do you bite your lips or cheeks regularly	☐ **YES**	☐ **NO**
Is your mouth sensitive to hot, cold or pressure? Where?_____	☐ **YES**	☐ **NO**
Does food catch between your teeth? Where? _____	☐ **YES**	☐ **NO**
Do you feel nervous about having dental treatment?	☐ **YES**	☐ **NO**

Explain any bad experience with previous dental work. _____

OCCLUSAL SCREENING

Do you clench or grind your teeth during the day?	☐ **YES**	☐ **NO**
Do you clench or grind your teeth during the night?	☐ **YES**	☐ **NO**
Do you have chronic headaches or neck and shoulder pain?	☐ **YES**	☐ **NO**
Do you ever wake up with an awareness of your teeth or jaw, as if you've had them clenched in your sleep?	☐ **YES**	☐ **NO**
Do the muscles in your neck or shoulders hurt?	☐ **YES**	☐ **NO**
Do you have a tight or stiff neck?	☐ **YES**	☐ **NO**
Do you now or have you ever had pain in your jaw joint or the sides of your face (in and around your ears)?	☐ **YES**	☐ **NO**
Do you have clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?	☐ **YES**	☐ **NO**
Do you know the meaning of traumatic occlusion?	☐ **YES**	☐ **NO**

Which side do you chew on? ☐ **RIGHT** ☐ **LEFT** ☐ **BOTH**

Do we have your permission to photograph your mouth and teeth?	☐ **YES**	☐ **NO**
Have you had a hysterectomy?	☐ **YES**	☐ **NO**

TMJ SCREENING

Are you experiencing headaches, jaw pain, jaw stiffness or facial muscle spasms?	☐ **YES**	☐ **NO**
Does your jaw get stuck open or closed?	☐ **YES**	☐ **NO**
Do bright lights bother you?	☐ **YES**	☐ **NO**
Do you have noises, ringing, itching or stuffiness of the ears?	☐ **YES**	☐ **NO**
Do you have pain in the jaw joints in front of the ears, the upper or lower teeth or the facial muscles?	☐ **YES**	☐ **NO**
Is it difficult or painful to open your mount wide enough to eat?	☐ **YES**	☐ **NO**
When you chew, do you have clicking, grating or popping sounds in your jaw joints?	☐ **YES**	☐ **NO**
Have you been diagnosed with migraines?	☐ **YES**	☐ **NO**
Does your bite feel different or is there pain while chewing?	☐ **YES**	☐ **NO**
Do your teeth hurt?	☐ **YES**	☐ **NO**
Are your teeth sensitive to hot or cold?	☐ **YES**	☐ **NO**
Do you clench or grind your teeth at night?	☐ **YES**	☐ **NO**
Do you have acid reflux?	☐ **YES**	☐ **NO**
Do you fall asleep while reading?	☐ **YES**	☐ **NO**
Do you fall asleep while watching television?	☐ **YES**	☐ **NO**
Do you lie down to rest in the afternoon when circumstances permit?	☐ **YES**	☐ **NO**
Do you feel like sleeping after a lunch that does not include alcohol?	☐ **YES**	☐ **NO**