



ARIZONA CENTER
FOR LASER DENTISTRY

Drs. Enrico & Roberto DiVito
General, Cosmetic, Laser Dentistry
Non-Surgical TMJ Management
7900 E. Thompson Peak Pkwy.
#101Scottsdale, AZ 85255
480-990-1905 • Fax 480-990-2311

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:

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

ARE YOU NOW:

- | | | |
|---|---|--|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> On a prescribed diet | <input type="checkbox"/> Using thyroid pills |
| <input type="checkbox"/> Using anticoagulants | <input type="checkbox"/> Using anti-depressants | <input type="checkbox"/> Blood Pressure Med |

ARE YOU NOW TAKING OR USING MEDICATION FOR:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes (pills or shots) | <input type="checkbox"/> Nerves (tranquilizers) | <input type="checkbox"/> Arthritis or rheumatism |
| <input type="checkbox"/> Stomach (ulcer, other) | <input type="checkbox"/> Blood (liver/iron pills) | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> 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:

- | | | |
|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Other |
| <input type="checkbox"/> 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 mouth 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