Jeffrey S. Rouse, **DDS, PA** – Specialist in Prosthodontics
Lisa D. Rouse, **DDS** – General Dentistry

Thank you for the opportunity to evaluate your dental condition. In order to provide the best service for you, please complete the following patient information

ABOUT YOU

Last Name:		First Name:
Address:		
City:	State:	Zip:
Home #:	Work#:	Mobile#:
email:	Male/Female	S.S.#:
Date of Birth:	Marital Status:	Employer:
Who can we thank for referring you?		

RESPONSIBLE PARTY ❑ SAME AS ABOVE

Last Name:	First Name:
Date of Birth:	S.S.#
Employer:	Work#:

INSURANCE INFO (if applicable) ❑ SELF PAYING

Insurance Company:		ID#
Claims Address:		
City:	State:	Zip:
Provider Phone:		Group#:
Policy Holder:	DOB:	Relationship to Patient:
Group Name/Employer:		

ADDITIONAL INSURANCE INFORMATION

Secondary Dental Plan:	Group#:
Policy Holder:	DOB:
Group Name/Employer:	S.S.#:

DENTAL HEALTH

What is your immediate concern? _____

_____

_____

_____

Please answer YES or NO to the following:

PERSONAL HISTORY

Are you fearful of dental treatment?	YES NO
Have you had an unfavorable dental experience?	YES NO
Have you ever had complications from past dental treatment?	YES NO
Have you ever had trouble getting numb or had any reactions to local anesthetic?	YES NO
Did you ever have braces, orthodontic treatment or had your bite adjusted?	YES NO
Have you had any teeth removed?	YES NO

GUM & BONE

Do your gums bleed or are they painful when brushing or flossing?	YES NO
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	YES NO
Have you ever noticed an unpleasant taste or odor in your mouth?	YES NO
Is there anyone with a history of periodontal disease in your family?	YES NO
Have you ever experienced gum recession?	YES NO
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	YES NO
Have you experienced a burning sensation in your mouth?	YES NO

TOOTH STRUCTURE

Have you had any cavities within the past 3 years?	YES NO
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	YES NO
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	YES NO
Are you teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	YES NO
Do you have grooves or notches on your teeth near the gum line?	YES NO
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	YES NO
Do you frequently get food caught between any teeth?	YES NO

BITE & JAW JOINT

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	YES NO
Do you feel like your lower jaw is being pushed back when you bite your teeth together?	YES NO
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	YES NO
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	YES NO
Are your teeth crowding or developing spaces?	YES NO
Do you have more than one bite and squeeze to make your teeth fit together?	YES NO
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	YES NO
Do you clench your teeth in the daytime or make them sore?	YES NO
Do you have any problems with sleep or wake up with an awareness of your teeth?	YES NO
Do you wear or have you ever worn a bite appliance?	YES NO

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change?	YES NO
Have you ever whitened (bleached) your teeth?	YES NO
Have you felt uncomfortable or self-conscious about the appearance of your teeth?	YES NO
Have you been disappointed with the appearance of previous dental work?	YES NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

_____

_____

_____

MEDICAL HEALTH

Name & Address of Physician _____

Have you been under a physicians's care during the past 2 years? No___ Yes___ – if yes, why? _____

_____

Have you been treated in a hospital in the past 2 years? No___ Yes___ – if yes, why? _____

_____

Are you now or have you taken any prescription drugs during the past year? No___ Yes___ – if yes, please list? _____

_____

Do you use TOBACCO products? No___ Yes___ – if yes, please list? _____

Have you ever been told that you should be on antibiotics before having dental work? _____

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Local anesthesia ❑ Other _____

Indicate which of the following you have had, or have at present. **Circle Yes or No to each item**.

Yes No **Heart Disease**	Yes No **Angina**	Yes No **Jaundice**	Yes No **HIV**
Yes No **Arthritis**	Yes No **Kidney Disease**	Yes No **Diabetes**	Yes No **Artificial Heart Valves**
Yes No **Liver Disease**	Yes No **Heart Murmur**	Yes No **Artificial Joints**	Yes No **Organ Transplant**
Yes No **Hepatitis**	Yes No **Asthma**	Yes No **Pacemaker**	Yes No **Pregnant or Trying**
Yes No **Cancer**	Yes No **Polio**	Yes No **Prolonged Bleeding**	Yes No **Chemotherapy**
Yes No **Prolonged Cough**	Yes No **Rheumatic Fever**	Yes No **Congenital Heart Lesions**	Yes No **Psychiatric Treatment**
Yes No **Stroke**	Yes No **Drug Dependency**	Yes No **Radiation Therapy**	Yes No **Tuberculosis**
Yes No **Epilepsy**	Yes No **Sickle Cell Anemia**	Yes No **Abnoraml Blood Pressure**	Yes No **Fainting**
Yes No **Thyroid Disease**	Yes No **Allergies**	Yes No **Glaucoma**	Yes No **Ulcers**
Yes No **Anemia**	Yes No **Herpes**	Yes No **Venereal Disease**	

Do you have any disease, condition, or problem not previously listed? _____

_____

Have you recently used illegal drugs? Yes No _____

SLEEP APNEA

The following survey has been provided to aid you in diagnosing and curing issues that might be related to Snoring, Upper Airway Resistance and Sleep Apnea.

Please circle your condition, using Epworth's 0-3 Sleepiness Scale, during the following activities.

0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

1. Sitting and reading.	0 | 1 | 2 | 3
2. Watching television.	0 | 1 | 2 | 3
3. Sitting inactively in a public place.	0 | 1 | 2 | 3
4. As a passenger in a car for an hour without a break.	0 | 1 | 2 | 3
5. Lying down to rest in the afternoon.	0 | 1 | 2 | 3
6. Sitting and talking to someone.	0 | 1 | 2 | 3
7. Sitting quietly after lunch w/o alcohol.	0 | 1 | 2 | 3
8. Driving a car stopped in traffic or at a stop light.	0 | 1 | 2 | 3
9. Have you ever been told you snore?	YES NO
10. Do you wake up fatigued?	YES NO
11. Do you have morning tension/migraine headaches?	YES NO
12. Have you been diagnoses with chronic fatigue syndrome, irritable bowl syndrome, fibromyalgia or Temporomandibular Syndrome? _____	YES NO

13. Any additional comments that may be helpful? _____

_____

FOR DOCTOR NOTES ONLY

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I hereby authorize Dr. Jeffrey Rouse and partners to perform procedures, including but not limited to: giving anesthetics and medications: making radiographs and photographs to be used in professional presentations or journals: performing oral, head, & neck examination, removing and restoring teeth: any necessary prosthodontic therapy. I certify that I have read and fully understand the above consent to treatment. I authorize release of any information necessary to process my insurance claim and, also, hereby authorize payment of insurance benefits to Jeffrey S. Rouse, DDS. A copy of this signature is valid as the original. Your name and signature also indicate that you have received a copy of our Notice of Privacy Practices on the date indicated.

Signature:_____ Date:_____