Surname:_____ **First:**_____ **Gender:**_____

Date of Birth:_____ **Nationality:** _____ **Languages:**_____

Phone No: _____ **Email Address:**_____

BSN for Children (under 18yrs) – with Dutch Insurance _____

Dental Hygiene

How often do you brush your teeth? _____

Do you use any of the following: dental floss - tooth picks - interdental brushes – other_____

Type of toothbrush: Manual Electric

Today's visit is for a consultation (Intake) and X-rays - please list any dental issues you would like to discuss with the dentist:

_____

Last dental appointment: _____ **Country:**_____

Last X-rays:_____ **List if known: – Bitewings - PA/Solo - Panoramic/OPT.**

(Please email previous X-rays and dental records to ihchdental@ezorg.nl to be placed in your file)

Health History

Use of tobacco products: YES / NO Type:_____ **Frequency:**_____

Alcoholic intake: YES / NO Frequency/Units per day: _____

Currently under medical treatment: YES / NO Please explain:_____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Please explain:

_____

Are you taking any medication, including non-prescription medicine? YES / NO

Please list medications:_____

Are you allergic to any of the following? YES / NO

◯ Aspirin ◯ Penicillin ◯ Local Anesthetics ◯ Any metal ◯ Latex

◯ Other If yes, please explain:_____

Do you clench or grind your teeth?	◯ **Yes**	◯ **No**
Do your gums bleed while brushing or flossing?	◯ **Yes**	◯ **No**
Do you have any broken tooth?	◯ **Yes**	◯ **No**
Are your teeth sensitive to hot or cold liquids/food?	◯ **Yes**	◯ **No**
Are your teeth sensitive to sweet or sour liquids/food?	◯ **Yes**	◯ **No**
Do you feel pain to any of your teeth?	◯ **Yes**	◯ **No**

If yes, please explain where/which kind of pain: _____

Have you experienced any of the following problems in your jaw?

Clicking	◯ **Yes**	◯ **No**
Pain (joint, ear, side of face)	◯ **Yes**	◯ **No**
Difficulty opening or closing	◯ **Yes**	◯ **No**
Difficulty in chewing	◯ **Yes**	◯ **No**
Do you have frequent headaches?	◯ **Yes**	◯ **No**
Have you ever had any difficult extractions in the past?	◯ **Yes**	◯ **No**
Have you ever had any prolonged bleeding following extractions?	◯ **Yes**	◯ **No**
Do you wear dentures, dental prosthesis or an ortho appliance?	◯ **Yes**	◯ **No**

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ◯ **Yes** ◯ **No**

MRA: Mandibular Repositioning Appliance
Do you wear an oral appliance at night for snoring or for sleep apnea? ◯ **Yes** ◯ **No**
(Please mention to your dentist if you would like to receive more information about what we can offer for these problems)

Please indicate if you have ever had any of the following conditions:

◯ **High Blood Pressure**	◯ **Heart Disease**	◯ **Liver disease**
◯ **Heart Attack**	◯ **Anaemia**	◯ **Glaucoma**
◯ **Rheumatic Fever**	◯ **Frequently Tired**	◯ **Respiratory Problems**
◯ **Fainting/Seizures**	◯ **Cancer**	◯ **Other**
◯ **Asthma**	◯ **Arthritis**	**_____**
◯ **Low Blood Pressure**	◯ **Joint Replacement/ Implant**	**_____**
◯ **Epilepsy/Convulsions**	◯ **Hepatitis type _____**	
◯ **Leukaemia**	◯ **Sexually Transmitted Disease**	
◯ **Diabetes**	◯ **Digestive Disorders**	
◯ **Kidney Disease**	◯ **Chest Pains**	
◯ **AIDS/HIV Infection**	◯ **Stroke**	
◯ **Thyroid Problems**	◯ **Tuberculosis**	

Female Patients

Are you pregnant or think you may be pregnant? ◯ **Yes** ◯ **No** **Are you breast feeding?** ◯ **Yes** ◯ **No**

I have answered the questions to the best of my knowledge. I understand that withholding pertinent information may affect a full diagnosis. It is my responsibility to inform the dental office of any changes in my medical status. I give permission for the IHCH Dental Clinic to record my personal data and health history until further notice.

I understand that if I miss an appointment or decide to cancel with less than 24hrs notice, I will be charged a fee

I understand that Payment is due at time of service for all patients *(exception is children under 18yrs with proof of Dutch dental insurance coverage).*

_____ _____

Signature of Patient, Parent or Guardian **Date**