GREAT
NORTHERN DENTAL CARE
RONALD JARVIS, DDS

85 Village Loop • Kalispell, MT 59901
Office | (406)257-5696 Fax | (406) 257-5697
Email | info@greatnortherndentalcare.com

Patient Name: ____ DOB: _______________ Date: ______________

DENTAL HISTORY QUESTIONNAIRE

When was your last dental exam? _________________
Cleaning? ________________ Xrays? ________________

What are you hoping to accomplish with your dental visit today? ________________________________
____

When discussing my treatment plan, I prefer to focus on: ❑ Immediate Needs ❑ Broad Overview ❑ Detailed (Tooth by Tooth)

What are the most important things to you about your smile and dental health? ____________________
____

I think my present state of dental health is:
❑ Poor ❑ Fair ❑ Good ❑ Excellent

Please check any of the following that apply:
- ❑ Sensitivity: ❑ Hot ❑ Cold ❑ Biting ❑ Sweet
- ❑ Headaches, earaches, neck pain
- ❑ Grinding or clenching teeth
- ❑ Pain or discomfort in the jaw
- ❑ Broken teeth or fillings
- ❑ Bleeding, swollen, or irritated gums
- ❑ Loose, tipped, or shifting teeth
- ❑ Missing teeth
- ❑ Bad Breath
- ❑ Snoring/Sleep Concerns
- ❑ Unhappy with previous dental treatment
- ❑ Periodontal disease (gum disease)

Do you feel nervous or anxious about dental treatment?
❑ No ❑ Slightly ❑ Moderately ❑ Extremely
Please explain____________________________________
____

Do you have or have you had any of the following?
- ❑ Orthodontics (braces)
- ❑ Dentures/Partials
- ❑ Nightguard
- ❑ Orthodontic Retainer

If you could change your smile, would you:
- ❑ Make your teeth whiter
- ❑ Make your teeth straighter
- ❑ Close spaces between your teeth
- ❑ Replace silver/metal fillings
- ❑ Repair broken teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns
- ❑ Have a smile makeover

How often do you brush? ________________________
Brush is: ❑ Electric ❑ Soft ❑ Medium ❑ Hard
Do you use? ❑ Floss ❑ Mouthwash ❑ Fluoride ❑ Waterpik ❑ Other ___________________________

How often do you consume sweetened drinks (coffee, tea, soda, juice, energy drinks, etc) and foods? ❑ Occasionally ❑ 2-3 times per month ❑ Weekly ❑ Daily

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MEDICAL HISTORY QUESTIONNAIRE

How do you rate your current physical condition?
❑ Good ❑ Fair ❑ Poor

Are you under the care of a physician? ❑ Yes ❑ No
Physician Name ____________________
Phone ______________ Last visit ________

Do you have or have had any of the following?

❑ Abnormal Bleeding	❑ Hemophilia
❑ Arthritis: Osteo/Rheumatoid	❑ High Blood Pressure
❑ Artificial Heart Valve	❑ HIV or AIDS
❑ Asthma/Respiratory	❑ Joint Replacement
❑ Cancer	❑ Kidney Disease
❑ Chemotherapy	❑ Liver Disease
❑ Dry Mouth	❑ Lupus
❑ Diabetes: Type I or II	❑ Pacemaker
❑ Epilepsy	❑ Psychiatric Disorders
❑ Excessive Thirst/Urination	❑ Osteoporosis/penia
❑ Fainting or Dizziness	❑ Radiation Therapy
❑ Heart Disease or Attack	❑ Seizures
❑ Heart Murmur	❑ Sinus Problems
❑ Heart Surgery	❑ Stroke
❑ Heartburn or GERD	❑ Thyroid Problems
❑ Hepatitis	❑ Tuberculosis (TB)

Do you have any medical conditions not listed above? ____________________
____

Have you had any serious health problems or hospitalizations in the last 5 years? ❑ Yes ❑ No
If yes, explain ____________________
____

Have you been advised to take antibiotics prior to your dental appointment? ❑ Yes ❑ No

Are you taking any medications, supplements, or herbs? ____________________
____
____

Have you had any allergic or adverse reactions to any of the following?

❑ Acetaminophen (Tylenol)	❑ Latex
❑ Aspirin	❑ Local Anesthetics
❑ Codeine Or Opiates	❑ Penicillin
❑ Ibuprofen (Advil)	❑ Other Antibiotics

❑ Other: ____________________

Do you use tobacco products? ❑ Yes ❑ No ❑ Quit
What kind? ____________________
How often? __________ How long? __________
Do you vape? ❑ Yes ❑ No
Do you use any of the following?
❑ Cannabis ❑ CBD ❑ Recreational Drugs

Have you had a sleep study done? ❑ Yes ❑ No
If yes, when? ____________________
Do you use a CPAP/Sleep Device? ❑ Yes ❑ No

Women Only
Are you currently? ❑ Pregnant ❑ Nursing
Have you ever taken? ❑Osteoporosis Medications

To the best of my knowledge all of the preceding answers are accurate and correct. If I have any changes in my health status or if my medications change, I will inform the dentist and staff as a change in medical health can affect dental treatment.

____
Signature of Patient, Guardian Date