



GETTING TO KNOW YOU

Welcome to transcendentist and the office of Dr. Fred Pockrass! We are committed to your total well-being and to helping you take the best care of your mouth. We know this is an extensive questionnaire, and thank you for taking the time to answer as completely as possible.

What is your name? _____

How would you like to be addressed? _____

ABOUT YOU

Please give us your full mailing address.

Address, including apt #	City	State	Zip
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Do you have an e-mail address? _____

We do not share e-mail addresses with anyone

What is your birth date? _____

What is your age? _____

Please provide us with the following telephone numbers: [Please check the best number for us to reach you.](#)

Home: () _____ Work: () _____ Cell: () _____

Please provide an emergency contact person and contact information (if the information is different from yours).

_____ () _____

Name	Phone
------	-------

Address, including apt #	City	State	Zip
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Relationship: _____

Would you like to have whiter teeth? Yes No

Have you used whitening products or methods in the past? If so, please tell us what you have tried.

There are new technologies such as invisible braces that allow us to straighten teeth without metal braces. Is that of interest to you? Yes No

Are you concerned with the way your breath smells? Yes No

DENTAL HYGIENE

Do you use a manual toothbrush or an electric toothbrush?

Please tell us the brand(s), (e.g. Sonicare, Oral-B).

Do you enjoy brushing your teeth? Yes No

How many times a day do you brush? 1 x day 2 x day More

Do you floss? (Be honest) Never Occasionally 1 x day 2 x day

What brand floss do you use?

Do your gums bleed when you brush or floss? Almost always Often Occasionally Never

If you have any teeth where food gets stuck or floss shreds, please tell us about it.

Have you ever been told to take antibiotics before dental treatments or teeth cleaning? Yes No

DENTAL EXPERIENCES

What do you like best about going to the dentist?

What do you like least about going to the dentist?

When you were a child, how would you describe your dental experiences? (If you are a child, please complete this section or ask your parent to help.) Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Wonderful. I felt supported and remember mostly pleasant experiences. | <input type="checkbox"/> Unpleasant. I'd rather forget these experiences. |
| <input type="checkbox"/> Good. Everything was generally fine. | <input type="checkbox"/> Fearful. I was almost always afraid to go to the dentist. |
| <input type="checkbox"/> Uneven. Some were good, some not so good. | |

As an adult, how would you describe your dental experiences? (If you are a child, please skip this section) Please check all that apply.

- Wonderful. I almost always feel supported and have mostly pleasant experiences.
- Good. Everything is generally fine.
- Uneven. Some are good, some not so good.
- Unpleasant. I'd rather forget these experiences.
- Fearful. I am almost always afraid to go to the dentist.

Do you have fear or anxiety associated with dental visits? Yes No

If so, how have you coped? _____

GENERAL HEALTH AND WELL-BEING

Please rate your general health and well-being. Excellent Good Fair Not so good

If you are currently being treated for any medical condition, please tell us about it.

If you currently have a physician or wellness practitioner, please provide us with the name(s) and contact information.

Name () Phone

Address, including suite # City State Zip

Name () Phone

Address, including suite # City State Zip

If you are currently receiving any complementary medicine or alternative medical care such as acupuncture, homeopathy or chiropractic, please tell us about it.

Are you currently taking medications? Please tell us what you are taking and why. Include prescriptions and over the counter medications.

	Name	Reason	How often?	How long?
1.				
2.				
3.				
4.				
5.				

Do you regularly taking vitamins or supplements? If so, please tell us what you are taking and why.

	Name	Reason	How often?	How long?
1.				
2.				
3.				

Are you allergic to, or have you had an adverse reaction to any of the following? If you answer yes to any of the below, please give us more information (e.g. which antibiotics you are allergic to and what reaction you've had).

		<u>Name of Substance</u>	<u>Reaction</u>
Antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Aspirin, Advil or other anti-inflammatory medicines	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Base metals, e.g. nickel, lead	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Codeine or other pain medicines	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Dental Anesthetics "Numbing"	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Dental Materials	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Fluoride	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Latex/Latex Sensitive	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Nitrous Oxide	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____

Have you ever been tested for biocompatibility with dental materials? If so, please give us detail, (e.g. Clifford Reactivity Test, Sept 2002, no sensitivities). _____

Have you ever had any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal bleeding (Prolonged) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemakers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial bones/joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dizziness/fainting spells | <input type="checkbox"/> HIV+ /AIDS | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease |

FOR WOMEN

Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you nursing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you take birth control pills?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you in transition to menopause?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

PLEASE BE SURE TO READ AND SIGN THE FOLLOWING:

Financial Practices & Consent
Acknowledgement of dental materials fact sheet & privacy practices

We look forward to serving you!