Christopher D. Dorr, D.M.D.
Special Interest in Endodontics

TELL US ABOUT YOUR DENTAL SYMPTOMS

First Name: _____ Last Name: _____

1. Are you experiencing any pain at this time? If not, please go to Question 5. ___Yes ___ No

2. If yes, can you locate the pain? ___Yes ___No

3. When did you first notice the symptoms?_____

4. Did symptoms occur suddenly or gradually? _____

Please check the frequency and quality of the discomfort, and circle the number that most closely reflects the intensity of your pain:

Level of Intensity
(On a scale of 1 to 10)
1= Mild, 10= Severe
1 2 3 4 5 6 7 8 9 10

Frequency
___Constant
___Intermittent
___Momentary
___Occasional

Quality
___Sharp
___Dull
___Throbbing

Is there anything you can do to relieve the pain? ___Yes ___No

If yes, what?_____

Is there anything you can do to cause the pain to increase? ___Yes ___No

If yes, what? _____

When eating or drinking, is your tooth sensitive to: Heat ___ Cold___ Sweets___

Does your tooth hurt when you bite down or chew? ___Yes ___No

Does a change in posture (lying down or bending over) cause your tooth to hurt? ___Yes ___No

5. Do you grind or clench your teeth? ___Yes ___No

6. If so, do you wear a night guard? ___Yes ___No

7. Has a restoration (filling or crown) been placed on this tooth recently? ___Yes ___No

8. Prior to this appointment, has root canal therapy been started on this tooth? ___Yes ___No

9. Any past trauma or injury to this tooth? ___Yes ___No

10. If the answer to the preceding question is yes, describe past trauma and state the occurrence date.

_____

11. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis? _____

(Signature of Patient/Parent/Legal Guardian)_____Date_____

Brewer Dental Specialists, P.A.

CHRISTOPHER D. DORR D.M.D. Endodontist

237 Wilson Street Brewer, ME 04412

Phone: (207) 991-9570 • Fax: (207) 991-9588

Patient Name_____

Allergies to medications	
Use the chart below to list all medications, both prescription and nonprescription, you are allergic to.	
Medication name	**Type of reaction, such as a rash or breathing difficulties**

Prescription medications				
Use the chart below to list **all** the brand-name and generic prescription medications you currently take. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the prescription label in milligrams (mg). The dosage is the amount of medication in each pill multiplied by the number of pills you take each time.				
Medication name	**Prescribing doctor's name**	**Reason for taking the medication**	**Dosage (in mg)**	**How often? (such as 3x/day)**

Medication name	Prescribing doctor's name	Reason for taking the medication	Dosage (in mg)	How often? (such as 3x/day)

Nonprescription medications, vitamins, and supplements			
List all those you take occasionally, such as aspirin for headache, as well as those you take every day, such as a multivitamin or nutritional supplement. Include any herbs or alternative medicines that you take.			
Name	**Reason for taking the medication**	**Dosage (in mg)**	**How often? (such as 3x/day)**

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Today's Date ____/____/____

Patient's Name _____ Phone _____

Cell # _____

Social Security Number _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address if different from Mailing Address _____ City _____ Zip _____

Patient's Dentist _____ Patient's Physician _____

Whom may we thank for referring you to our office? _____ Dentist _____ Other _____

Employed By: _____ Occupation _____

Business Address _____ Phone _____

____ Single ____ Married ____ Separated ____ Divorced ____ Widowed

Spouse's Name _____ Social Security #_____ D.O.B. _____

Employed By: _____ Occupation _____

Business Address _____ Phone _____

_____ Due to Federal HIPPA Guidelines, I have reviewed a copy of the Notice of Privacy Practices when I arrived for my appointment. I hereby give permission for this office to discuss treatment, appointment scheduleline, &/or finances for the above patient to immediate family members ____ Yes ____ No

***Full payment is due at the time of service unless other prior arrangements have been made with this office, Brewer Dental Specialists, P.A. (BDSPA). There is a $25.00 fee for any checks returned by the bank for any reason. If I default on this agreement, I understand I will be charged 18% per annum in late fees on any outstanding balance and that I will also be responsible for any/all associated costs for court or collection action of any type. By my/our signature(s) I/we also agree to accept full financial responsibility for the child(ren) listed below. If I/we default on payment to BDSPA that I/we will be liable to the extent permitted by law, for BDSPA's collection costs, court costs, and attorney fees, in collecting this account.

Patient's Signature _____ Date _____

Spouse Signature _____ Date _____

SPOUSE SIGNATURE REQUIRED IF PATIENT IS UNEMPLOYED OR IF SPOUSE IS THE INSURED

Person filling out this form: _____ Relationship _____

INSURANCE INFORMATION (Providing this information will allow our office to generate an actual claim form for you to submit to your dental insurance for direct reimbursement for your payment to us)

Primary Dental Insurance Company _____

Insurance Claims Address _____ 800 tel. # _____

Subscriber _____ Certificate or ID# _____

Subscriber's address if different than patient _____

Patient's relationship to insured _____ Self _____ Spouse Group # _____

Secondary Dental Insurance Company _____

Insurance Claims Address _____ 800 tel. # _____

Subscriber _____ Certificate or ID# _____

Patient's relationship to insured _____ Self _____ Spouse Group # _____

I hereby authorize Brewer Dental Specialists, P.A. to submit claims to my insurance company(ies) and that I am responsible for all balances not covered by insurancec for ANY reason.

_____

Signed Date

○ I require antibiotic prophylaxis prior to dental treatment.
Condition: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No _____
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Are you currently taking or have you previously taken bisphosphonate medications such as Actonel, Fosomax or Zometa within the past twelve years? ○ Yes ○ No _____

Women: Are you
☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

★ SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____