**Grant D. Ringler, DDS**
**Justin L. Barnhart, DDS**
**Melissa C. Barnhart, DDS**

3008 Garden Grove Parkway
Hutchinson, KS 67502
620.669.0835 Office
620.669.0559 Home
888.OPN.WIDE

# Dental Health History

Today's Date: ____________

**Patient Name:** ______________________________ Birthdate: ____/____/____

## Dental History

**Reason for Today's Visit:** ______________________ Date of last dental care: ____________

Check [X] if you have had problems with any of the following:

[ ] Bad Breath [ ] Grinding Teeth [ ] Bleeding Gums [ ] Clicking/popping jaw
[ ] Loose Teeth [ ] Broken fillings [ ] Periodontal Treatment [ ] Sensitivity to cold
[ ] Other ______________________________

How often do you floss? ______________ How often do you brush? ______________

## Medical History

**Primary Care Physician:** ______________________________

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 any serious head or neck injury? [ ] Yes [ ] No If yes, please explain: ______________

Do you require Pre-Med antibiotics before dental treatment? [ ] Yes [ ] No If yes, why: ______________

Do you use tobacco? [ ] Yes [ ] No If yes: [ ] Chewing tobacco [ ] Smoke

Do you use controlled substances? [ ] 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 [ ] Sulfa Drugs [ ] Latex/Iodine [ ] Local Anesthetics
[ ] Other ______________________________

______________________________

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

[ ] Anemia
[ ] Arthritis
[ ] Artificial Heart Valves
[ ] Artificial/Replacement Joints
[ ] Asthma
[ ] Back Problems
[ ] Blood Disease
[ ] Cancer
[ ] Circulatory Problems
[ ] Chemical Dependency
[ ] Chemotherapy
[ ] Cold Sores
[ ] Cough, Persistent
[ ] Cortisone Treatment
[ ] Diabetes
[ ] Epilepsy
[ ] Emphysema/Respiratory Disorder
[ ] Fainting/Dizziness
[ ] Gastro-Esophageal Reflux Disease
[ ] Glaucoma
[ ] Headaches
[ ] Heart Problems
[ ] Heart Murmer
[ ] Hemophilia/Abnormal Bleeding
[ ] Hyper/Hypothyroid
[ ] Hepatitis A/B/C
[ ] High/Low Blood Pressure
[ ] HIV/AIDs
[ ] Jaw Pain
[ ] Kidney Disease
[ ] Liver Disease
[ ] Mitral Valve Prolapse
[ ] Pacemaker
[ ] Previous Biopsies
[ ] Radiation Treatment
[ ] Rheumatic Fever
[ ] Sinus Trouble
[ ] Tuberculosis
[ ] Osteoporosis

**List any medications you are currently taking:** ______________________________

______________________________

______________________________

In case of emergency, notify: ______________________ Phone #. ______________

I authorize the dentist to release any information including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I have answered the above health/medical form accurately and to the best of my ability. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment at time of service rendered on my behalf or my dependents.

Patient Signature: ______________________________ Date: ______________

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Serving our patients better with dental concerns & interests including whitening, straightening teeth, grinding, clenching, missing teeth, dental solutions, cosmetic solutions, fears and anti-aging is our goal. Thank you for taking time to let us know the ways we can serve you more thoroughly.

**Brushing and Flossing**

| | | |
|---|---|---|
| Are you currently using only a manual toothbrush? | YES | NO |
| Do you feel you could do a better job of cleaning between your teeth? | YES | NO |
| Are your teeth sensitive? | YES | NO |
| Do your gum tissues bleed? | YES | NO |
| Is the prevention of periodontitis or gingivitis (gum disease) a concern? | YES | NO |

**Clenching and Grinding**

| | | |
|---|---|---|
| Do you grind your teeth? | YES | NO |
| Do you clench your teeth? | YES | NO |
| Do your teeth show signs of wear? . | YES | NO |
| Are you bothered by persistent headaches or migraine attacks? | YES | NO |

**Teeth Whitening**

| | | |
|---|---|---|
| Are you happy with your present tooth shade? | YES | NO |
| Do you see others with healthy, white teeth and wish your teeth looked the same? | YES | NO |
| Have you noticed your teeth becoming increasingly yellow? | YES | NO |
| Do you entertain habits that cause your teeth to darken? ex: Wine, Coffee | YES | NO |
| Have you considered professional teeth whitening procedures? | YES | NO |
| Are you interested in dental anti-aging improvements? | YES | NO |

**Cosmetic Improvements**

| | | |
|---|---|---|
| Are you concerned about gaps, spaces, over-crowding and misaligned teeth? | YES | NO |
| Have you considered cosmetic improvements such as crowns? | YES | NO |

**Implants**

| | | |
|---|---|---|
| Are you bothered and concerned about missing teeth? | YES | NO |
| Have you considered dental implants for a solution? | YES | NO |

**6 Months Smiles**

| | | |
|---|---|---|
| Have you worn braces in the past and now notice shifting of your teeth? | YES | NO |
| Do you have crowding and spaces that bother you? | YES | NO |
| Does the appearance of your teeth keep you from smiling? | YES | NO |
| Do you know about 6 Month Smiles? | YES | NO |

**Sedation Dentistry**

| | | |
|---|---|---|
| Do fears of dentistry keep you from taking care of needed dental issues? | YES | NO |
| Have you had a bad dental experience in the past? | YES | NO |
| Are you interested in learning more about conscious and deep sedation methods? | YES | NO |