



**DINO MANTIS DDS**  
1625 N. SHERIDAN RD. WILMETTE ILLINOIS 60091  
(847) 256-4776 - DRDINOMANTIS.COM

## WELCOME TO OUR OFFICE

### PATIENT INFORMATION:

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK to call work  Yes  No  
Cell phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Pager (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_  
S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F Birthday \_\_\_\_\_  
 Married  Divorced  Separated  Widowed  Single

### RESPONSIBLE PARTY INFORMATION:

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK to call work  Yes  No  
Cell phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Pager (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_  
S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  M  F Birthday \_\_\_\_\_  
 Married  Divorced  Separated  Widowed  Single

### ADDITIONAL INFORMATION:

Phone number of the nearest relative not living with you (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Whom do we thank for referring you? \_\_\_\_\_ Other source \_\_\_\_\_

**I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. A MONTHLY CHARGE OF 1.5% PER MONTH WILL BE ADDED ON ALL ACCOUNTS NOT PAID WITHIN 30 DAYS.**

*I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and use of the same by the doctor in scientific papers or demonstrations.*

Date: \_\_\_\_\_ Signature of patient/guardian \_\_\_\_\_

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
 Name of Physician/and their specialty \_\_\_\_\_  
 Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_  
 What is your estimate of your general health?  Excellent  Good  Fair  Poor

**DO YOU HAVE or HAVE YOU EVER HAD:**

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			32. neurologic problems _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (i.e. heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>		
13. emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY

Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor  
 Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years  
 Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

## PERSONAL HISTORY

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
|   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or reactions to local anesthetic? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## SMILE CHARACTERISTICS

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth? _____                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you self conscious about your teeth? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work? _____            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## BITE AND JAW JOINT

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
|   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you / would you have any problems chewing gum? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you / would you have any problems chewing bagels or other hard foods? _____                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are your teeth crowding or developing spaces? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have tension headaches or sore teeth? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you wear or have you ever worn a bite appliance? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## TOOTH STRUCTURE

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
|   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had any cavities within the past 3 years? _____                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a dry mouth? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are any teeth sensitive to hot, cold, biting or sweets? _____                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you avoid brushing any part of your mouth? _____                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## GUM AND BONE

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever experienced gum recession? _____                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Is there anyone with a history of periodontal disease in your family? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do your gums bleed when brushing, flossing or eating? _____                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are your teeth becoming loose? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever noticed an unpleasant taste or odor in your mouth? _____       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you experienced a burning sensation in your mouth? _____                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_