Welcome to the National Breath Center

Thank you for selecting our team! We will strive to provide you with the best possible care. To help us meet all your dental/healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information **Date** ______________________

Name ____

Address ____

City, State, Zip ____

Soc. Sec. No. ____________________ Birthdate ____________________ Age ____________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home No. _________________Work No. ________________ Email______________________

Employer _____________________________ Occupation _____________________________

Business Address (Street, City, State, Zip) ____

____

Responsible Party

Who is responsible for the account?

Name ____

Relationship to patient ____

Home Phone No. _________________________Work Phone No. ________________________

Soc. Sec. No. ____________________ Birthdate ____________________ Age ____________

Address ____

City, State, Zip ____

Employer ____________________________ Occupation _____________________________

Business Address (Street, City, State, Zip) ____

____

Who may we thank for referring you to our office? ____

In the event of an emergency, who should we contact? _____________________________________

Relationship ______________________________ Phone No. ___________________________

MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care, it is important you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Name ____ Date of Birth ______________________________ ☐ Male ☐ Female

Height _______________ Weight ________________ Home Phone _________________________

MEDICAL HISTORY

Name and address of physician ____

When was your last physical examination? ____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, for what reason? ____

Are you presently taking any medications/drugs/pills? ☐ Yes ☐ No
Please list ____
____

Are you allergic (or have an allergic reaction) to:
☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ None ☐ Other ____

Are you sensitive or allergic to latex? Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon? Have you had any unusual or unexplained reactions during a surgical procedure?
☐ Yes ☐ No Explain ____

(Women) Are you pregnant? ☐ Yes ☐ No If yes, how long? ____

Do you have, or have you ever had:

Condition			Condition		
Heart (Trouble, Disease, Surgery)………………	☐ Yes	☐ No	Arthritis/Rheumatism……………………	☐ Yes	☐ No
Heart murmur……………………………………	☐ Yes	☐ No	Cortisone medicine………………………	☐ Yes	☐ No
Heart pacemaker………………………………..	☐ Yes	☐ No	Excessive or prolonged bleeding………..	☐ Yes	☐ No
Rheumatic fever or Rheumatic heart disease…….	☐ Yes	☐ No	Blood Transfusions………………………	☐ Yes	☐ No
Congenital heart defects…………………………	☐ Yes	☐ No	Hemophilia………………………………	☐ Yes	☐ No
Artifical heart valve………………………………	☐ Yes	☐ No	Sickle Cell Disease………………………	☐ Yes	☐ No
Mitral valve prolapse…………………………..	☐ Yes	☐ No	Fainting spells…………………………..	☐ Yes	☐ No
Abnormal blood pressure…………………......	☐ Yes	☐ No	Asthma or hay fever……………………	☐ Yes	☐ No
Ulcers……………………………………………	☐ Yes	☐ No	Emphysema………………………………	☐ Yes	☐ No
Tuberculosis or lung disease……………………..	☐ Yes	☐ No	Sinus trouble…………………………...	☐ Yes	☐ No
Diabetes…………………………………………..	☐ Yes	☐ No	Cancer/Tumors/Lesions…………………	☐ Yes	☐ No
Epilepsy…………………………………………..	☐ Yes	☐ No	Chemotherapy/radiation…………………	☐ Yes	☐ No
Anemia……………………………………………	☐ Yes	☐ No	Stroke……………………………………	☐ Yes	☐ No
Thyroid problems…………………………………	☐ Yes	☐ No	Glaucoma…………………………………	☐ Yes	☐ No
Recreational drug use…………………………..	☐ Yes	☐ No	Psychiatric care/eating disorder…………	☐ Yes	☐ No
Chemical dependency…………………………..	☐ Yes	☐ No	Neurological disorders…………………	☐ Yes	☐ No
Kidney problems…………………………………	☐ Yes	☐ No	Prosthetic implant/artificial joint………..	☐ Yes	☐ No
Liver disease……………………………………	☐ Yes	☐ No	Venereal disease………………………	☐ Yes	☐ No
Jaundice…………………………………………	☐ Yes	☐ No	HIV positive/AIDS/ARC…………………	☐ Yes	☐ No
Hepatitis – Type A B C ………	☐ Yes	☐ No	Hearing impaired……………………...	☐ Yes	☐ No

Have you had any other serious illness, hospitalization or accident? ☐ Yes ☐ No
If yes, please explain ____
____

B.P.

ACKNOWLEDGEMENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature ____ Date _________________________

DENTAL HISTORY

Are any of your teeth sensitive to:

Hot or Cold?……………………..………………….. ☐Yes ☐No
Sweets?……..……………………………………… ☐Yes ☐No
Biting or pressure?….………………………………. ☐Yes ☐No

Do you frequently get cold sores,
blisters or any lesions?…………………… ☐Yes ☐No

Do your gums bleed or hurt?..……………….…… ☐Yes ☐No

Does food tend to become caught
between your teeth?……………………….. ☐Yes ☐No

Do you:
Clench or grind your teeth while awake or asleep? … ☐Yes ☐No
Have tired jaws, especially in the morning ?………… ☐Yes ☐No
Bite your lips or cheeks regularly? …………………. ☐Yes ☐No

Mouth breathe while asleep or awake?……………… ☐Yes ☐No
Snore?……………………………………………… ☐Yes ☐No
Smoke? Cigarettes,Vape, Tobacco, Marijuana?..… ☐Yes ☐No

Have you ever experienced:
Clicking or popping of the jaw……………………… ☐Yes ☐No
Pain? (joint, ear, side of face)..……………………… ☐Yes ☐No
Difficulty opening or closing the mouth?…………… ☐Yes ☐No
Frequent headaches, neckaches, or
shoulder aches?…………………………… ☐Yes ☐No
Any pain or soreness in the muscles of
your face or around the ears? ….…………. ☐Yes ☐No

Have you ever had:

Orthodontic treatment?…………………..... ☐Yes ☐No
Oral surgery?…….…………………….....… ☐Yes ☐No
Teeth removed?…………………………..... ☐Yes ☐No
If so, have they been replaced?......... . ☐Yes ☐No

Periodontal Treatment? …………………… ☐Yes ☐No
Gum Surgery?……………………………..… ☐Yes ☐No
If so,when?_______________________________
By whom? _______________________________
Your teeth ground or the bite adjusted? …… ☐Yes ☐No
A serious injury to the mouth or head? …… ☐Yes ☐No
If so, please describe. Include cause ______________
____

Are you dissatisfied with the appearance
of your teeth? ………………….......... ☐Yes ☐No
Are your teeth discolored?… …………..… ☐Yes ☐No

Would you like to change the appearance of
your teeth?……………………….......... ☐Yes ☐No

Have you ever had an upsetting dental
experience?………….……………… ☐Yes ☐No

If so, please describe ___________________________
____
____

Is there anything else about having dental treatment that you would like us to know, please describe.
____
____
____

HALITOSIS QUESTIONNAIRE

The following questions are important in our ability to help you eliminate your halitosis. Please think about them before answering. The more information you provide, the better we will be able to help you.
NOTE: ALL INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NEVER BE GIVEN OUT

Name ____ Date ___________________

How do you know you have halitosis?

_____ Non-verbal communications of others
_____ Someone told me
_____ I just know
_____ I can taste it

Please explain your answer here:

How long have you had it? _______ years

What was your first experience where you knew you had bad breath? When?

How intense is your Bad Breath? Rate it from 1-10 where 10 is the most severe. (CIRCLE)

1 2 3 4 5 6 7 8 9 10

Describe why you feel that way here.

Do you have a way to smell your own breath?

_____ I lick the back of my hand and smell it
_____ I breath into my (cupped) hands and smell it
_____ I wipe a gauze on my tongue and smell it
_____ I smell my tongue cleaner (scraper)

If you can smell it, what does it smell like?

Do you also have a bad taste? _____ Yes _____ No

If Yes, what does it taste like? Please describe.

Do you associate the bad taste with your breath? Yes No

At what distance do you think Your Bad Breath Is Noticeable? _________ feet

Do You Have a Dry Mouth? If Yes, do you do anything to treat it?

Do you have a history of Sinus problems? Respiratory problems? _____ Yes _____ No
If Yes, please Explain here.

Do you have any problems with GAS? CONSTIPATION? DIARRHEA? (If Yes, please CIRCLE and explain)

Does your food have an unusual taste? _____ Yes _____ No If Yes, what does it taste like?

How is Bad Breath Affecting Your Social Life? Your Work Life? Your Relationships? PLEASE DESCRIBE
(I understand that this is a difficult question to answer but remember that our goal is to help you live a better life with the elimination of your breath problem. The more we know, the more we can help.)

Have you consulted Any Other Professionals for Your Halitosis? If so, please note the type of Doctor and any **Tests You Had Done, the Results, and What You Were Told** next to it.

_____ Dentist

_____ Dentist(s)

_____ Family Doctor

_____ ENT

_____ Internal Medicine

_____ Other Professional

_____ Other

What Do You Currently Do to Treat Your Breath Problem? Also List How Many Times per Day.

Do you smoke? Yes No I quite _____ years/months ago.