Steven C. Maurstad, D.D.S.

Patient Information

Name: _____
Last First MI

Address: _____
Number and Street City State Zip code

_____ M F
Home Phone Business Phone - Ext. Social Security Number Date of Birth Sex

cell phone_____ e-mail_____

Responsible Party Information

Name: _____
Last First MI

Address: _____
Number and Street City State Zip code

_____
Home Phone Business Phone - Ext. Social Security Number Date of Birth

Employer: _____ _____
Employer Phone

Address: _____
Number and Street City State Zip code

Dental Insurance Company _____
Address: _____
Number and Street City State Zip code

_____ _____
Group Number Insurance Company Phone Number

Secondary Dental Insurance Information

Employer: _____ _____
Employer Phone

Address: _____
Number and Street City State Zip code

Dental Insurance Company: _____
Address: _____
Number and Street City State Zip code

_____ _____
Group Number Insurance Company Phone Number

I learned of Dr. Maurstad's practice from: _____

Person to contact in case of emergency

_____ _____ _____
Name Daytime Phone Evening Phone

_____
Signature of Patient or Guardian Date

Steven C. Maurstad, D.D.S.

Medical History Questions

How would you describe your current state of health? _____

_____

Are you a health oriented person? _____

What do you do on a regular basis to improve your health? _____

When was your last complete medical examination? (Physical) _____

Family Physician _____ Specialty _____

Additional Physician _____ Specialty _____

Do you have or have you had any of the following: (Please circle Y for Yes and N for No)

Y N	Heart trouble	Y N	Hepatitis A or B or C	Y N	Pain in the Chest
Y N	Joint Replacement	Y N	HIV+	Y N	Headaches
Y N	High Blood Pressure	Y N	Tumor or Cancer	Y N	Easily Fatigued
Y N	Kidney Disease	Y N	Arthritis	Y N	Shortness of Breath
Y N	Liver Disease	Y N	Asthma	Y N	Persistent Cough
Y N	Stroke	Y N	Hay Fever	Y N	Fainting or Dizziness
Y N	Diabetes	Y N	Sleep Apnea	Y N	Latex allergy
Y N	Tuberculosis	Y N	Allergic to Medications	Y N	Major Operation
Y N	Anemia	Y N	Ulcers	Y N	Serious Accident
Y N	Tobacco Dependency	Y N	Prolonged Bleeding		
Y N	Alcohol Dependency	Y N	Nervous Disorder	Y N	Pregnant Now
Y N	Drug Dependency	Y N	Psychiatric Treatment	Y N	Menopause

If you marked yes to any of the above please explain in the space provided below

_____

_____

_____

_____

_____

_____

_____

What medications are you now taking? Including non-prescription medications.

Medication	Dosage	How many	How Frequent	For what Condition

_____

Signature of Patient or Guardian Date

Dental Questionnaire

Last First Name you want to be called

Correct answers to the following questions will allow Dr. Maurstad to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? _____ [] Yes [] No
2. Have you ever had any serious trouble associated with previous dentistry? _____ [] Yes [] No
3. Does dental treatment make you nervous? _____ [] No [] Slightly [] Moderately [] Extremely
4. When was the date of your last dental visit? _____
5. Have you ever been treated for periodontal disease (gum disease, gingivitis, pyorrhea)? [] Yes [] No
6. How often do you brush?_____ My brush is : [] Soft [] Medium [] Hard
7. Do you have or have you ever had any of the following:

MOUTH		TEETH	
Bleeding, sore gums	[] Yes [] No	Loose teeth	[] Yes [] No
Unpleasant taste/bad breath	[] Yes [] No	Sensitive to hot	[] Yes [] No
Burning tongue/lips	[] Yes [] No	Sensitive to cold	[] Yes [] No
Frequent blister, lips/mouth	[] Yes [] No	Sensitive to sweets	[] Yes [] No
Swelling/lumps in mouth	[] Yes [] No	Sensitive to biting	[] Yes [] No
Ortho treatment (braces)	[] Yes [] No	Food getting caught	[] Yes [] No
Biting cheeks/lips	[] Yes [] No	Clenching/grinding	[] Yes [] No
Clicking/popping jaw	[] Yes [] No	If so, when	_____
Difficulty opening/closing jaw	[] Yes [] No	Shifting in bite	[] Yes [] No
		Change in bite	[] Yes [] No

8. Do you use the following?

Brush	[] Yes [] No	Dental Floss	[] Yes [] No
Fluoride rinse	[] Yes [] No	Other []	_____

These are the things that are important to me about my dental health: _____

Do you fear dental care?_____ If so, what are those fears?_____

Please circle one for each statement:

1. My mouth is ..... a) very comfortable b) moderately comfortable c) uncomfortable	5. I..... a) have always done the best that was recommended for my dental health b)have not done what dentists have recommended to me c) rarely go, and don't care much about having any dental work completed
2. I..... a) think the appearance of my mouth is excellent b) am satisfied with the appearance of my mouth c) am dissatisfied with the appearance of my mouth	6. I..... a) have put dentistry for myself and my family high on my priority list b) have put dentistry for myself and my family low on my priority list c) Dentistry is on my list but it's hard to find
3. I..... a) will do anything to keep my natural teeth b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them	7. I think my present state of dental health is a) Excellent b) Good c) Poor
4. I..... a) have set goals for my oral health with a previous dentist b) want to set goals concerning my dental health	8. I aspire to a mouth with: a) Excellent health b) Good health c) Poor health

What are some questions about dentistry and oral health that you have never had adequately answered?

Temperomandibular Disorder Questions

Do you have or have you had any of the following: (Please circle Y for Yes and N for No)

Y N Do you clench, clamp or grind your teeth while you are sleeping?
Y N Has anyone ever told you that they have heard you grind your teeth while sleeping?
Y N Must you chew on one side exclusively?
Y N Do you have any symptoms upon waking in the morning such as :

Y N Stiff Jaw?	Y N Sore Face or Jaw Muscles?
Y N Sore Jaw?	Y N Tired Face or Jaw Muscles?
Y N Sore Teeth?	Y N Cracking of the Jaw Joint?
Y N Headache?	Y N Locking of the Jaw Joint? (Difficulty in opening?)

Y N Does your jaw feel tired after a big meal or after eating very "chewy" food?
Y N Does your jaw get locked open?
Y N Does your jaw get locked closed?
Y N Does it hurt when you chew?
Y N Does it hurt when you open wide to take a big bite?
Y N Do you have pain in your ears while eating?
Y N Do you have pain in front of your ears while eating?
Y N Do you have pain in your:

Y N Shoulder?	Y N Eyes?
Y N Neck?	Y N Back?
Y N Throat?	Y N Jaw?
Y N Face?	Y N Temples?

How often do you suffer from Headaches? Describe them.

Y N Does pain or discomfort disturb your sleep? How often:
Y N Does pain or discomfort interfere with your daily routine or other activities?
Y N Have you ever had whiplash? When?
Y N Have you ever had a severe head injury? When?
Y N Have you ever had a severe jaw injury? When?
Y N Do you have a nervous stomach?
Y N Do you consider yourself to be under more stress than most people?
Y N Do you take tablets for nervousness, depression or to help you relax?
Y N Do you take medicine for pain? What do you take?
Y N Have you ever been treated for jaw joint pain or discomfort?
Please list date, place and names of doctors who have treated you for this.

Please comment on any medical history or dental history that you feel may be important in the diagnosis of any jaw joint condition (you may have heard these called TMD or TMJ).

Signature of Patient or Guardian Date