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

Emergency Dental Questionnaire

Name: _____

First Last Name you prefer 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. Not all of these questions will apply to your circumstance, please feel free to leave any blank that do not apply to you.

1. How can we help You?_____
2. Are you having any discomfort at this time? [] Yes [] No _____
3. Are you having any of the following:

MOUTH		TEETH	
Bleeding, sore gums	[] Yes [] No	Loose teeth	[] Yes [] No
Unpleasant taste/bad breath	[] Yes [] No	Teeth sensitive to hot	[] Yes [] No
Burning tongue/lips	[] Yes [] No	Teeth sensitive to cold	[] Yes [] No
Blisters, lips/mouth	[] Yes [] No	Teeth sensitive to sweets	[] Yes [] No
Swelling/lumps in mouth	[] Yes [] No	Teeth sensitive to biting	[] Yes [] No
Ortho treatment (braces)	[] Yes [] No	Food Impaction	[] 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

4. When did this problem start?_____
5. Has it been getting worse or better over time?_____
6. If you are having pain please describe it for us: [Dull or Sharp] [Throbbing or Steady] [Constant or On and Off]
7. Has this condition awakened you from sleep? [] Yes [] No _____
8. What time of day is the worse? [] All the time [] Morning [] Afternoon [] Evening [] Nighttime/sleeping
9. What have you done that makes it worse?_____
10. What have you done that makes it better?_____
11. Have you ever had this problem before? [] Yes [] No If Yes- In the same area? [] Yes [] No
12. What are some questions about this situation that you have?_____
13. What do you fear most about this situation?_____
14. Have you ever had any serious trouble associated with previous dentistry? [] Yes [] No _____
15. Does dental treatment make you nervous? _____ [] No [] Slightly [] Moderately [] Extremely
16. When was the date of your last dental visit?_____
17. Have you ever been informed that you have gum disease (gingivitis, pyorrhea)? [] Yes [] No
18. Have you ever been treated for gum disease, (gingivitis, pyorrhea)? [] Yes [] No
    If Yes, please explain_____

Signature_____ Date _____