

Date \_\_\_\_\_

Reason for today's visit:  Exam  Urgent  Consultation  Other  
Do you require antibiotics prior to dental treatment?  Yes  No  Don't know

Who requested that you visit this office? (Name) \_\_\_\_\_  MD  Dentist  Attorney  None (Self-Referral)

**What is your main reason for your visit? (check all that apply)**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Tooth Extraction(s)      | <input type="checkbox"/> Need Surgery for Tumor or Growth      | <input type="checkbox"/> Dry Mouth                          | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Wisdom Teeth             | <input type="checkbox"/> Facial Surgery (Orthognathic Surgery) | <input type="checkbox"/> Burning Mouth                      |  |
| <input type="checkbox"/> Dental Implants          | <input type="checkbox"/> Need to be Sedated for Surgery        | <input type="checkbox"/> Oral Sores / Blisters / Ulcers     |  |
| <input type="checkbox"/> Tooth / Facial Infection | <input type="checkbox"/> TMJ Problems                          | <input type="checkbox"/> Lumps / Bumps / Swellings in Mouth |  |
| <input type="checkbox"/> Jaw / Facial Fracture    | <input type="checkbox"/> Oral or Facial Pain                   | <input type="checkbox"/> Salivary Gland Problems            |  |

Have you already seen other physicians, surgeons or dentists for your problems?  Y  N Please list below.

Provider \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_\_  
 Provider \_\_\_\_\_ Specialty \_\_\_\_\_ Date \_\_\_\_\_

**ALL PATIENTS**

**-Do you have a dental, oral or facial problem?  Y  N (If 'yes', fill the areas below):**

-How long ago did your problem start? \_\_\_ Days \_\_\_ Weeks \_\_\_ Months \_\_\_ Years.

-Have you had a problem like this before?  Y  N

-On a scale of 0-10 (10 is the worst) how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

-What is the quality of the pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning \_\_\_\_\_

The pain is:  Constant  Comes and goes (intermittent). Does your pain wake you from sleep?  Yes  No

• Do you have?  Swelling  Bruise  Numbness  Tingling  Weakness

Since my problem started, it is:  Getting better  Getting worse  Unchanged

What makes your symptoms worse?  Heat  Cold  Eating  Spicy foods  Sugary foods  Opening / Closing Jaw  
 Other \_\_\_\_\_

Which make your symptoms better?  Rest  Heat  Cold  Other \_\_\_\_\_

Which medications are you taking now (or previously) for this problem? \_\_\_\_\_

**For Office Use Only:**

Vitals: BP \_\_\_\_\_ Pulse \_\_\_\_\_ T \_\_\_\_\_ Weight \_\_\_\_\_ Pain 0 1 2 3 4 5 6 7 8 9 10

**ASA Class:** I II III IV

**DOCTOR SIGNATURE** \_\_\_\_\_  
Date \_\_\_\_\_

**ADVANCE DIRECTIVES**

- Patient given Advance Directive Information Date \_\_\_\_\_ / Staff Signature \_\_\_\_\_  
 Patient has Advance Directive – Copy placed on chart Date \_\_\_\_\_ / Staff Signature \_\_\_\_\_



**Carolinas Center for Oral Health  
New Patient Oral Medicine/Oral Surgery**

Name:  
DOB:  
Medical Record #:

08/08/07