Craig A. Zunka, DDS
107 W. 4th Street
Front Royal, VA

TODAY'S DATE: _____

Welcome!

In order to provide you with the best possible care please complete both sides of this form. All information is completely confidential.

PATIENT INFORMATION: *PLEASE PRINT*

Name: _____
Last *First* *Middle Initial*

Name you prefer to be addressed by: _____

Mailing address: _____

Residence *(If different than your mailing)*: _____

Home Telephone #: ( ) _____ Business #: ( ) _____ Email: _____

Patient's Date of Birth: ___/___/___ Patient's Social Security #: ___/___/___

Employer: _____ Employer's Address: _____

SPOUSE INFORMATION: *PLEASE PRINT*

Spouse's Name: _____
Last *First* *Middle Initial*

Spouse's Social Security #: ___/___/___ Employer _____

Employer's Address: _____

Employer's Telephone #: ( ) _____ Date of Birth: ___/___/___

IF THE PATIENT IS A MINOR... *(If Applicable)*

_____ _____
Father's Last Name *First Name* *Mother's Last Name* *First Name*

Father's SS#: ___/___/___ Mother's SS#: ___/___/___

Father's Date of Birth: ___/___/___ Mother's Date of Birth: ___/___/___

Father's Employer: _____ Mother's Employer: _____

Employer's Address: _____ Employer's Address: _____

Employer's Telephone #: ( ) _____ Employer's Telephone #: ( ) _____

How did you hear of Dr. Zunka? _____

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

NOTICE TO MEDICARE PATIENTS!!! Dr. Zunka **does not participate with Medicare and is not a Medicare provider**. All treatment incurred from this office must be paid at the time service is rendered. Your signature on this form is indication to Dr. Zunka, his office and to Medicare that you have been notified according to Medicare and Federal regulations.

DENTAL HISTORY

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning? _____ Full Mouth X-rays? _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes / No

If yes, please describe: _____

Would you like to keep all your teeth? Yes / No Nervous about dental treatment? Yes / No

Why? _____

PLEASE CIRCLE ALL THAT APPLY (PAST OR RECENT)

Bad Breath/Taste

Bleeding Gums/Pain

Sensitive to Hot

Sensitive to Cold

Sensitive to Sweets

Orthodontics—past/present

Mouth Pain

Mouth Breathing

Fingernail Biting

Burning On Tongue

Serious injury to mouth or head

Lip or cheek chewing

Cigarette, cigar smoking, chewing tobacco & snuff

Dental Implants

Headaches/Neck aches/Shoulder aches

Grinding teeth/Clenching teeth

Difficulty opening/closing

Jaw pops or clicks

Jaw Pain

Sores or growths in mouth

Loose or broken teeth

Mouth guard or bite plate

Periodontal treatment

Family history of Periodontal Disease

Chewing on one side only

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

_____

_____

THIS BOX - OFFICE USE ONLY

Medical Alerts: _____

_____

Patient Name: _____ Date of Birth: _____

Address: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

ALLERGIES: Are you allergic to or had a reaction to any of the following?

Yes/No	Local Anesthetics	Yes/No	Codeine	Yes/No	Narcotics _____
Yes/No	Amoxicillin	Yes/No	Aspirin	Yes/No	Barbiturates or Sedatives
Yes/No	Penicillin	Yes/No	Iodine	Yes/No	Flavors, Dyes, Chemicals
Yes/No	Sulfa Drugs	Yes/No	Latex	Yes/No	OTHER _____
Yes/No	Tetracycline	Yes/No	Metabisulfites		_____

MEDICAL HISTORY

**********Please CIRCLE YES or NO for all.**********

Yes/No	Acid Reflux/GERD	*Yes/No*	Hepatitis ___ (Type)
Yes/No	A.I.D.S.	*Yes/No*	Have you been hospitalized in the last 2 years?
Yes/No	Allergies (Seasonal)		_____
Yes/No	Allergies (Food/Dyes)		*(If yes, Why?-list date and name of physician)*
Yes/No	Anorexia		
Yes/No	Arthritis/Rheumatism	*Yes/No*	Kidney Disease
Yes/No	Artificial Joint(s) _____/ __Year	*Yes/No*	Latex Allergy/Sensitivity
Yes/No	Asthma	*Yes/No*	Learning Disability
Yes/No	Autism	*Yes/No*	Light/Photo Sensitivity
Yes/No	Blood Pressure (Low/High)	*Yes/No*	Liver Disease
Yes/No	Blood Transfusion __ Year	*Yes/No*	Lyme's Disease
Yes/No	Bruises Easily	*Yes/No*	Mitral Valve Prolapse
Yes/No	Bulimia	*Yes/No*	MRSA _____Area of body/ __ Year
Yes/No	Cancer (Type) _____/ __Year	*Yes/No*	Nervous/Anxious
Yes/No	Celiac Disease	*Yes/No*	Neurological Disorder
Yes/No	Chemotherapy	*Yes/No*	Nursing
Yes/No	Chest Pain	*Yes/No*	Osteoporosis
Yes/No	Chronic Cough	*Yes/No*	Osteonecrosis
Yes/No	Cold Sores/Fever Blisters	*Yes/No*	Pregnant ____ months
Yes/No	Congenital Heart Disease	*Yes/No*	Psychiatric/Physiological Disorder
Yes/No	Contact Lenses	*Yes/No*	Radiation Therapy (Area of body? _____)
Yes/No	Cortisone Medicine	*Yes/No*	Rheumatic Fever
Yes/No	Diabetes (Type___)	*Yes/No*	Sickle Cell Anemia
Yes/No	Dental Implants – Titanium	*Yes/No*	Sinus Trouble
Yes/No	Dental phobia	*Yes/No*	Smoker _____ packs per day
Yes/No	Diet (Special/Restricted)	Yes/No	Chewing Tobacco
Yes/No	Emphysema	*Yes/No*	Stroke
Yes/No	Fainting/Dizzy Spells	*Yes/No*	Swelling
Yes/No	Glaucoma	*Yes/No*	Swollen Ankles
Yes/No	Hay Fever	*Yes/No*	Thyroid Problems
Yes/No	Hearing Impaired/Loss	*Yes/No*	Tuberculosis
Yes/No	Heart Attack ____ Year	*Yes/No*	Tumors
Yes/No	Heart Surgery _____/ __Year	*Yes/No*	Ulcers
Yes/No	Heart Disease	*Yes/No*	Venereal Disease/STD's
Yes/No	Heart Murmur	*Yes/No*	Whooping Cough
Yes/No	Heart Pacemaker/Stints	*Yes/No*	Vision Impaired/Loss
Yes/No	Hemophilia	*Yes/No*	Yellow Jaundice

***CONTINUED ON BACK ---------->**

PLEASE WRITE <u>ANY/ALL</u> OTHER MEDICAL CONDITIONS NOT LISTED ABOVE ON THE LINES BELOW:

_____

_____

Primary Physician's Name: _____ Phone: _____

When was your last visit to your Primary Physician? _____ What for? _____

Has your primary medical doctor instructed you that you need to be Pre-Medicated? Yes/ No If yes, have you taken your pre-med today? ____

List **<u>all</u>** medications with dosages, ***<u>including vitamins and supplements</u>***, which you are taking:

_____

_____

_____

_____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the above questions to the best of my knowledge. I will notify the doctor/hygienist of ANY change in my health or medication. I am aware that this office participates in the VA Prescription Monitoring Program and may access my prescription record if needed.

Signature: _____ **Date:**_____

****STOP HERE! LINES BELOW WILL BE USED TO UPDATE YOUR HEALTH HISTORY IN THE FUTURE****

I HAVE REVIEWED MY MEDICAL HISTORY ABOVE. I HAVE NOTED ANY CHANGES ON THE LINES BELOW. If no changes, please write in "NO CHANGES".

DATE AND MEDICAL HISTORY CHANGES	**Patient Initials**	**STAFF**

Examiner _____
Date _____

OCCLUSAL SCREENING

Name _____ Male ❑ Female ❑ Age _____

Address _____

City/State/Zip _____ Telephone _____

If No Please ✔ Check
If Yes Please Rate 1, 2 or 3 (1 - Mild 2 - Moderate 3 - Severe)

	NO	YES	COMMENTS	Date				
1. Does it ever hurt when you chew?								
2. Does it ever hurt when you open wide or take a big bite?								
3. Does your jaw ever make noise?								
4. Do you ever have headaches?								
5. Do you ever have pain in front, in or behind the ear?								
6. Do you ever have tiredness, pulling or tightness in the head, neck or throat?								
7. Do you ever have a feeling of dryness or burning in the mouth?								
8. Do you ever have to search for a place to close your teeth?								
9. Does a tooth ever get in the way?								
10. Is a tooth ever sensitive or tender?								
			Occlusal Index Total					

COMPLETE THE QUESTIONS BELOW IF ANY YES RESPONSES ABOVE

	NO	YES	COMMENTS
1. Do you ever take anything for any of the above conditions?			
2. Have you ever had an injury or blow to the head or neck region?			
3. Have you had any recent dental treatments?			
4. Has your bite ever been changed?			
5. What do any of the above conditions stop you from doing?			

When the occlusal index totals five or more, or if one question has an index of three, complete the Objective Occlusal Examination.

OCCLUSAL EXAMINATION

1. **INTERCUSPAL POSITION:** ❑ IP=CR ❑ IP≠CR ❑ IP=MCP ❑ IP≠MCP
C.R. ❑ Straight **I.P. SLIDE:** ❑ Right ❑ Left
CR → CO Slide _____
R.C.P. SITE: ❑ Right ❑ Left ❑ Both

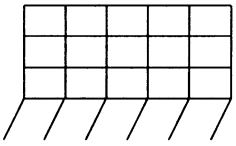
2. **TEMPOROMANDIBULAR SOUNDS:**

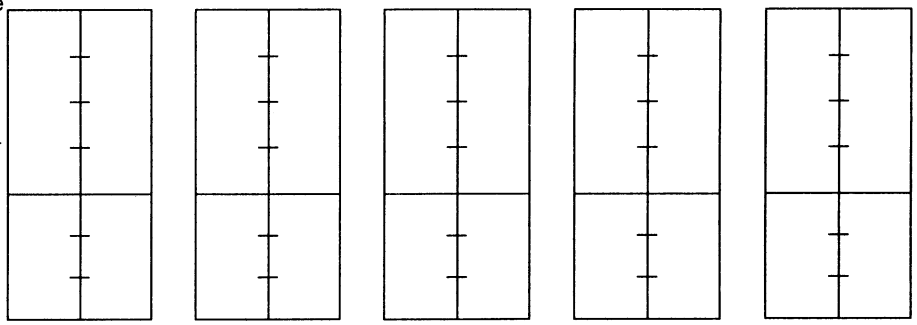
RIGHT	LEFT	
❑	❑	None
❑	❑	Intermediate
❑	❑	Terminal
❑	❑	Continuous

Date	RT	LF	RT	LF
	❑	❑	❑	❑
	❑	❑	❑	❑
	❑	❑	❑	❑

3. **JAW OPENING - CLOSING PATTERN**
___mm Maximum Opening
___mm Maximum Left Lat
___mm Maximum Right Lat
❑ Painful

Date / 40 mm →



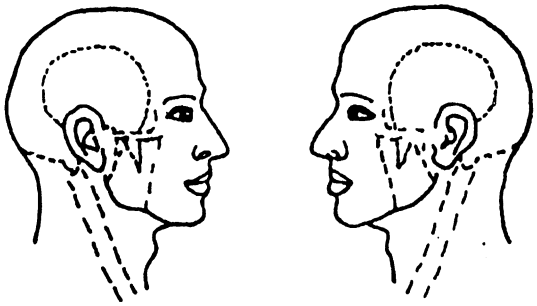


4. **RELATIONSHIP OF ANTERIOR TEETH IN I.P.:**
❑ Tooth Contact ❑ Gingival 1/3 ❑ Middle 1/3 ❑ Incisal 1/3
❑ Tissue Contact ❑ Open ❑ X-bite

5. **RELATIONSHIP OF POSTERIOR TEETH IN I.P.:**
Left Side ❑ Class I ❑ Class II ❑ Class III ❑ X-bite ❑ No Contact
Right Side ❑ Class I ❑ Class II ❑ Class III ❑ X-bite ❑ No Contact

6. **JAW MANIPULATION**

Easy	Difficult	
❑	❑	Hinge
❑	❑	Right Lateral
❑	❑	Left Lateral



7. **FACIAL PAIN AND PROVOCATION TEST:**

	i.e. Bruxofacets		Mobile Teeth		(7)
R	8 7 6 5 4 3 2 1	|	1 2 3 4 5 6 7 8		L
	8 7 6 5 4 3 2 1	|	1 2 3 4 5 6 7 8		

PROVOCATION RESPONSE ❑ None ❑ Positive

8. **ORAL - FACIAL PALPATION:**

			Date	RIGHT	LEFT
1)	TMJ capsule	lateral			
		posterior			
2)	Masseter	deep			
		superior			
3)	Temporalis	anterior			
		posterior			
4)	Vertex				
5)	Neck	nape			
		base			
6)	Sternocleidomastoid	origin			
		body			
		insertion			
7)	Medial Pterygoid				
8)	Posterior digastric				
9)	Temporalis Tendon				
10)	Lateral Pterygoid				

9. **NOXIOUS ORAL HABITS:**
❑ Deviate swallow ❑ Cheek or lip habit ❑ Nail Biter ❑ Other

10. **POSTURE**
Head _____
Shoulders _____
Pelvis _____
Leg _____

11. **DENTO-CRANIAL RESTRICTIONS**
1. _____
2. _____
3. _____
4. _____