Drs. Enrico & Roberto DiVito
General • Cosmetic • Laser Dentistry
Non-Surgical TMJ Management
7900 E. Thompson Peak Pkwy, Suite 101
Scottsdale, AZ 85255 • www.drdivito.com
P.480-990-1905 F.480-990-2311 T.480-845-0266

ARIZONA CENTER FOR LASER DENTISTRY

Purpose of visit: _____

☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss. _____
Last Name First Name Middle Initial Preferred Name

Address: _____
Street, Unit# City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ SS# _____ e-mail: _____

Responsible Party, if patient is a minor: _____ Relationship: _____

Occupation: _____ Employer: _____ No of Years: _____

Business Address: _____
Street, Unit# City State Zip Code

Whom may we thank for referring you to our office? _____

Name of Spouse: _____ Birth Date: _____ SS# _____

Cell Phone: _____ e-mail: _____

Employer: _____ Work Phone: _____

Landlord: _____ Phone: _____

Nearest relative not living with you: _____ Relationship: _____

Phone: _____ e-mail: _____

Whom may we contact in case of an emergency: _____ Phone: _____

Dental Insurance Co: _____ Phone: _____

Subscriber's Name: _____ Birth Date: _____ Member ID# _____

Medical Insurance Co: _____ Phone: _____

Payment is due on the day of treatment. Responsible party for payment: _____

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card ☐ 3rd Party Financing

I understand and agree that (regardless of my insurance status) I am responsible for the entire balance of my account at the time professional services are rendered. If insurance covers the procedure, insurance reimbursements will then be paid directly to me. Any accounts not paid in full will carry a billing fee of $25.00 per month. If suit is instituted to collect this note or any portion thereof, I promise to pay such additional sums as the court may adjudge reasonable as attorney's fees in said suit. Demand, presentment as for payment, protest and notice of protest are hereby waived. If necessary, I authorize this office to make inquiries with Credit Reporting Agencies regarding me, or if a married person, my marital community including my spouse. I hereby waive any confidentiality associated therewith.

I have read all the information on this sheet and have completed the answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature of Patient (or guardian of minor) _____ **Date:** _____

MEDICAL HISTORY

Name of Physician: _____ Date of last physical: _____

City/State: _____ Phone: _____

Do you have any current medical problems? ☐Yes ☐No If yes:_____

Do you smoke, vape or use tobacco? ☐Yes ☐No How much? _____

Do you drink coffee and/or soda? ☐Yes ☐No How much? _____

Have you ever had any of the following:

☐ Arthritis, sore joints	☐ Nervous Breakdown	☐ Heart Attack
☐ Diabetes	☐ Psychotherapy	☐ High Blood Pressure
☐ Stroke	☐ Asthma, Emphysema	☐ Low Blood Pressure
☐ Anemia, Leukemia	☐ Shortness of Breath	☐ Pain/Pressure/Tight Chest
☐ Epilepsy, fainting spells	☐ Swelling ankles/feet	☐ X-ray, Chemo, Radiation
☐ Convulsions	☐ Liver Disease	☐ Alcohol or Drug Abuse
☐ Headache	☐ Hepatitis, Jaundice	☐ Other: _____

Are you now:

☐ Pregnant	☐ On a prescribed diet	☐ Using thyroid pills
☐ Using Anticoagulants	☐ Using anti-depressants	☐ Other: _____

Are you now taking or using medication for:

☐ Diabetes (pills, shots)	☐ Nerves (tranquilizers)	☐ Arthritis, Rheumatism
☐ Stomach (ulcer, other)	☐ Blood (liver, iron pills)	☐ Allergies
☐ Heart or Blood Pressure	☐ Osteoporosis, Bone Disease	☐ Other: _____

Are you taking prescription or recreational drugs? ☐Yes ☐No List: _____

Have you ever been sick from, shown an allergy to or told not to take:

☐ Antibiotics: _____	☐ Codeine	☐ Aspirin
☐ Metals	☐ Latex	☐ Penicillin
☐ Tetracycline	☐ Sulfa Drugs	☐ Other: _____
☐ Novocain (or other dental anesthetic)		

Have you ever had a tumor or cancer? ☐Yes ☐No
What type, Date(s)? _____

Have you ever had a major operation? ☐Yes ☐No
What type, Date(s)? _____

Have you ever been in a serious accident? ☐Yes ☐No
Please describe: _____

Following injuries, have you ever had bleeding problems? ☐Yes ☐No

Do injuries and cuts take longer to heal now than previously? ☐Yes ☐No

Have you recently lost weight unintentionally? ☐Yes ☐No

Is there a history of diabetes in your family? ☐Yes ☐No

Have you ever had a joint replacement (hip, knee, elbow)? ☐Yes ☐No
What type, Date(s)? _____

Has a physician or previous dentist recommended antibiotics prior to dental treatment? ☐Yes ☐No

DENTAL HISTORY

Date of last examination: _____ Former Dentist: _____

Have you come to this office for relief of pain? ☐Yes ☐No

Have you had the pain more than 3 weeks? ☐Yes ☐No

Do your gums bleed when brushing your teeth? ☐Yes ☐No

Do you floss? If so, how often? _____ ☐Yes ☐No

Have you ever been diagnosed with Pyorrhea? ☐Yes ☐No

Do you bite your lips or cheeks regularly? ☐Yes ☐No

Is your mouth sensitive to hot, cold or pressure? Where? _____ ☐Yes ☐No

Does food catch between your teeth? Where? _____ ☐Yes ☐No

Do you feel nervous about having dental treatment? ☐Yes ☐No

Explain any bad experiences with previous dental work: _____

OCCLUSAL SCREENING

Do you clench or grind your teeth during the day? ☐Yes ☐No

Do you clench or grind your teeth during the night? ☐Yes ☐No

Do you have chronic headaches or neck and shoulder pain? ☐Yes ☐No

Do you ever wake up with an awareness of your teeth or jaw, as if you've had them clenched in your sleep? ☐Yes ☐No

Do the muscles in your neck or shoulders hurt? ☐Yes ☐No

Do you have a tight or stiff neck? ☐Yes ☐No

Do you now or have you ever had pain in your jaw joint or the sides of your face (in and around your ears)? ☐Yes ☐No

Do you have clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely? ☐Yes ☐No

Do you know the meaning of traumatic occlusion? ☐Yes ☐No

Which side do you chew on? ☐Right ☐Left ☐Both

Do we have your permission to photograph your mouth and teeth? ☐Yes ☐No

Have you had a surgical procedure(s) requiring you to be put to sleep? ☐Yes ☐No

TMJ SCREENING

Are you experiencing headaches, jaw pain, jaw stiffness or facial muscle spasms?	☐ Yes ☐ No
Does your jaw get stuck open or closed?	☐ Yes ☐ No
Do bright lights bother you?	☐ Yes ☐ No
Do you have noises, ringing, itching or stuffiness of the ears?	☐ Yes ☐ No
Do you have pain in the jaw joints in front of the ears, the upper or lower teeth or the facial muscles?	☐ Yes ☐ No
Is it difficult or painful to open your mouth wide enough to eat?	☐ Yes ☐ No
When you chew, do you have clicking, grating or popping sounds in your jaw joints?	☐ Yes ☐ No
Have you been diagnosed with migraines?	☐ Yes ☐ No
Does your bite feel different or is there pain while chewing?	☐ Yes ☐ No
Do your teeth hurt?	☐ Yes ☐ No
Are your teeth sensitive to hot or cold?	☐ Yes ☐ No
Do you clench or grind your teeth at night?	☐ Yes ☐ No
Do you have acid reflux?	☐ Yes ☐ No
Do you fall asleep while reading?	☐ Yes ☐ No
Do you fall asleep while watching television?	☐ Yes ☐ No
Do you lie down to rest in the afternoon when circumstances permit?	☐ Yes ☐ No
Do you feel like sleeping after a lunch that does not include alcohol?	☐ Yes ☐ No