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)

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

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