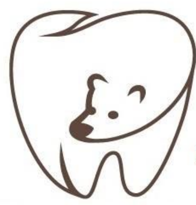


Yu Ting Wang, D.D.S
360 Stonebrook Pkwy, #110 Frisco, TX 75034 Tel: (469) 252-0522
Email: info@molarbeardental.com

New Patient Information

Name (Last, First Mi)		Date of Birth	Sex	Social Security Number
Preferred Name	**Home Phone Number**		**Cell Phone**	
Marital Status	**Guardian's Name & Relationship**		**Occupation**	
Home Address			**Work Phone Number**	
Email Address	**Dental Insurance**		**Dental Insurance ID Number**	
Dental Insurance Subscriber			**Subscriber Date of Birth**	
Other Family members that are patients here				

Emergency Contact Information		
I.E, who may we contact in case of an emergency (if it is spouse above you can indicate as below)		
Name	**Relationship**	
Home Phone Number	**Work Phone Number**	**Cell Phone Number**

Visit Information

How did you find out about us? If you were referred here, please let us know who referred you

____

____

Referred/Requesting evaluation for (check all that apply)

- ☐ Natural/Family Dentistry (Chemical free dental cleaning, fluoride free, BPA free dental fillings)
- ☐ Functional Dentistry (Breathing, sleep, nutrition, testing & safe treatment, growth & development)
- ☐ Baby/Infant airway development
- ☐ Orthopedic Orthodontics (ALF therapy)
- ☐ Adult sleep apnea analysis
- ☐ TMJ therapy (jaw joint therapy)
- ☐ Functional restoration (Function and smile make over)
- ☐ Alternative cosmetic procedures (Smoothlase/LipLase)
- ☐ Other (please indicate below)

  ____

We would like to thank you for trusting us with your oral health and taking your time to fill up the form. Let us tell you about our dental office. We are one of the only few holistic dental offices in the DFW area. We have not used amalgam fillings since the day our office opened. We use the finest bio-compatible materials. We offer a unique whole body approach to your health.
We limit radiation exposure to our patients. At your first visit you will take a digital low dose 3D scan rays **once** yearly.If you have different preferences, just let us know! We want you to feel comfortable about your dental care. For more information, please visit our website.

Do you have any other questions for us, or any concerns you wish for us to address?

____

____

In your own words, tell us what you would like help with and what your goals are for this first visit

____

____

Do you require any medications prior to dental procedures? ☐ Yes or ☐ No

If so, what medication (s) ____

Are you accustomed to seeing a dentist on a regular basis? ☐ Yes or ☐ No

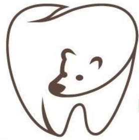
Please rate your comfort level with receiving dental treatment (Check below)

☐No Problem ☐Slightly Uneasy ☐Moderately Anxious ☐Please drag me out now

Please describe any problems you have had with past dental experiences.

____

____



MOLAR BEAR
FAMILY DENTAL
Integrated Biological Holistic Dentistry

Dental History

Please answer yes or no to the following:	Yes	No
Personal History		
1. Are you fearful of dental treatment?	☐	☐
2. Have you had any complications from past dental treatments?	☐	☐
3. Have you ever had trouble getting numb or reaction to local anesthesia?	☐	☐
4. Did you ever have braces, orthodontic treatments, or had your bite adjusted?	☐	☐
5. Have you had any teeth removed or missing teeth that never developed?	☐	☐
Gum and Bones		
6. Do your gums bleed or are they painful when brushing or floss?	☐	☐
7. Have you ever been treated for gum disease?	☐	☐
8. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
9. Is there anyone with a history of periodontal disease in your family?	☐	☐
10. Have you ever experience gum recession?	☐	☐
11. Have you ever had any teeth become loose on their own?	☐	☐
12. Have you experienced a burning/painful sensation in your mouth, not from your teeth?	☐	☐
Tooth Structures		
13. Have you had any cavities within the past 3 years?	☐	☐
14. Does the amount of saliva in your mouth seem too little, or do you have trouble swallowing?	☐	☐
15. Are any teeth sensitive to hot, cold, biting, or sweets?	☐	☐
16. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling	☐	☐
17. Do you frequently get food caught between any teeth?	☐	☐
Bite and Jaw Joint		
18. Do you have problems with your jaw joints? (pain, sounds limited movements)	☐	☐
19. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
20. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, or other hard/dry foods?	☐	☐
21. Are your teeth becoming more cooked, crowded or overlapped?	☐	☐
22. Are your teeth developing spaces or becoming more loose?	☐	☐
23. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
24. Do you chew ice, bite your nails, or have any other oral habits?	☐	☐
25. Do you clench your teeth in the daytime or make them sore?	☐	☐
26. Do you wear or have you ever worn a bite appliance	☐	☐
Smile Characteristics		
27. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
28. Have you ever whitened your teeth?	☐	☐
29. Have you been disappointed with the appearance of previous dental work?	☐	☐
Sleep Health		
30. Do you have any problems with sleep (restlessness, wake up with a headache)?	☐	☐
31. Has anyone told you that you are a snorer?	☐	☐
32. Do you often feel tired, fatigued or sleepy during the daytime?	☐	☐
33. Has anyone ever observed you stop breathing, chocking/gasping when you sleep?	☐	☐
34. Have you been or are treating with high blood pressure?	☐	☐
35. Do you usually fall asleep within 5 minutes?	☐	☐

Additional Dental Health Information

For the following section below, check the box that matches you

☐ My mouth is very comfortable ☐ My mouth is moderately comfortable ☐ My mouth is uncomfortable	☐ I think my dental health is excellent ☐ I think my dental health is good ☐ I think my dental health is poor
☐ I have set goals for my dental health ☐ I have never set goals for my dental health ☐ I want to set goals for my dental health	☐ I can chew all types of food comfortably ☐ I have difficulty chewing some foods ☐ I have difficulty chewing most hard/crunchy foods
☐ I think the appearance of my mouth is excellent and would change nothing ☐ I think the appearance of my mouth is ok ☐ I think my appearance of my mouth is not good ☐ I desire whiter teeth ☐ I desire straighter teeth	☐ I have generally chosen the highest quality dental option offered ☐ I have generally based my treatment choices on the initial cost ☐ I have rarely gone to the dentist and not complete treatment discussed
☐ I hope for excellent dental health care and repair ☐ I would like good dental health and repair ☐ I desire only urgent treatment	☐ I am familiar with Holistic Dentistry and its importance ☐ I am open to possibilities of Holistic Dentistry ☐ I am only interested in General Dental Care

Who are the alternative health care providers you have seen, and for what therapies?

____

____

Birth History

Were you ☐natural delivered or ☐ c-sectioned? Any special tools used? (vacuum)_______________________

Premature? ________________ Any complications with the birth or delivery? ________________________

Early Feeding

☐Bottle ☐Breastfed ☐Both bottle and breastfed ☐Difficulty during breastfeeding

☐no problem in early solid food introduction ☐History of food chocking

Any history of oral habits? (Thumb sucking, etc…) ___________________

Are you fully vaccinated? ☐ Yes ☐ No Note:____

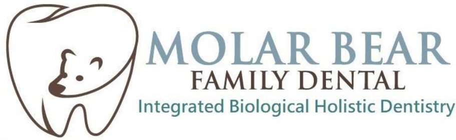
Any history of tonsillectomy or adenoidectomy? ☐ Yes. If so, Which year? _______________ ☐ No

Any history of tongue tie release? ☐ Yes. If so, any release or procedures? When? ______________ ☐ No

Any history of orthodontic treatment? (braces / palatal expansion) ☐ Yes. If so, when? _________ ☐ No

Are you using any alternative relaxation techniques (Yoga, meditation, etc) ☐ Yes ☐ No

Who is your primary care doctor/provider? _______________________ last check-up (date)?_____________



Medical History

Have you or have you EVER had the following below

	Yes	No
1. High Blood Pressure	☐	☐
2. Atherosclerosis	☐	☐
3. Congestive Heart Failure	☐	☐
4. Heart Attack	☐	☐
5. Infective Endocarditis	☐	☐
6. "Leaky" heart valves	☐	☐
7. Pacemaker/implanted defibrillator	☐	☐
8. Stroke	☐	☐
9. Abnormal bleeding	☐	☐
10. Anemia	☐	☐
11. Blood transfusion	☐	☐
12. Prolonged Bleeding	☐	☐
13. Asthma	☐	☐
14. Breathing or sleep problems	☐	☐
15. Emphysema	☐	☐
16. Tuberculosis	☐	☐
17. Kidney Problem	☐	☐
18. Liver Disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid Disease	☐	☐
21. Other Hormonal Deficiency _______	☐	☐
22. High cholesterol	☐	☐
23. Diabetes	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Gastric reflux issue	☐	☐

	Yes	No
26. Liver Disease	☐	☐
27. Kidney Disease	☐	☐
28. Arthritis	☐	☐
29. Osteoporosis	☐	☐
30. Systemic Lupus Erythematous	☐	☐
31. Seizure/Epilepsy	☐	☐
32. ADD/ADHD	☐	☐
33. Tumors/abnormal growth	☐	☐
34. Cancer	☐	☐
35. Sexually Transmitted Diseases	☐	☐
36. HIV/AIDS	☐	☐
37. Recurrent infections	☐	☐
38. TMD/TMJ	☐	☐
39. Chronic back pain	☐	☐
40. Chronic musculoskeletal pain	☐	☐
41. Migraine Headaches	☐	☐
42. Psychiatric illnesses	☐	☐
43. Autism Spectrum Disorder	☐	☐

Do you:

	Yes	No
Smoke	☐	☐
Drink Alcohol	☐	☐
Do any recreational drugs (marijuana, etc)	☐	☐

If you have any other significant medical problems not listed above, please write them below

____

____

Are you currently pregnant? ☐ Yes or ☐ No

Any surgeries in the past?

____

Do you have any allergies? If yes, please elaborate? ☐ No ☐ Yes: ______________________________

Please list all medications that you are currently taking

Drug:	Purpose	Drug	Purpose
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______