INTEGRATIVE

• DENTISTRY •

Health & Wellness Profile

INTENTIONAL. CONSERVATIVE. PERSONALIZED.

Our Philosophy

At Integrative Dentistry, we believe exceptional dental care begins with understanding the whole person—not just their teeth.

We intentionally care for one patient at a time, allowing us to listen carefully, understand your health story, and provide thoughtful, conservative recommendations that support your long-term wellness.

Every recommendation we make is guided by your health, your goals, and what we believe is in your best long-term interest.

We believe the mouth is deeply connected to the rest of the body, and we are honored to partner with you in achieving lasting health through compassionate, personalized care.

Thank you for trusting us with your care.

02 | About You

We'd love to get to know you.

Full Name

Preferred Name

Date of Birth

Phone Number

Email Address

Address

City

State

ZIP Code

Occupation

Emergency Contact Name

Emergency Contact Phone

Who may we thank for referring you?

We truly appreciate your referral.

What brings you to Integrative Dentistry?

Please share in your own words.

What are you hoping we can help you achieve?

What are your goals for your health and your smile?

03 | Your Health Story

Tell us about your overall health so we can provide care that is safe, thoughtful, and tailored to you.

Medical Conditions

Please select any conditions that apply.

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Diabetes / Prediabetes
- ☐ Thyroid disorder
- ☐ Autoimmune condition
- ☐ Osteoporosis / Osteopenia
- ☐ Cancer
- ☐ Sleep apnea
- ☐ TMJ disorder
- ☐ Chronic pain
- ☐ Anxiety / Depression
- ☐ Digestive disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Respiratory disease
- ☐ Neurological condition
- ☐ Other:

Please list any other medical conditions not listed above.

Medications

Please list all prescription and over-the-counter medications.

Supplements & Herbal Products

Please list all supplements, herbs, or natural products you take regularly.

Allergies & Sensitivities

Please list any allergies or sensitivities you have to medications, foods, substances, or environmental factors.

Your Healthcare Team

Primary Care Provider (optional)

Is there anyone else involved in your healthcare you'd like us to know about?

04 | Dental History & Your Smile

Help us understand your dental background and what matters most to you.

Dental History

Please select any that apply.

- ☐ Gum disease / Periodontal disease
- ☐ TMJ / Jaw pain
- ☐ Teeth grinding / Clenching
- ☐ Sensitive teeth
- ☐ Frequent headaches
- ☐ Previous orthodontic treatment
- ☐ Previous implants
- ☐ Other:

Your Goals

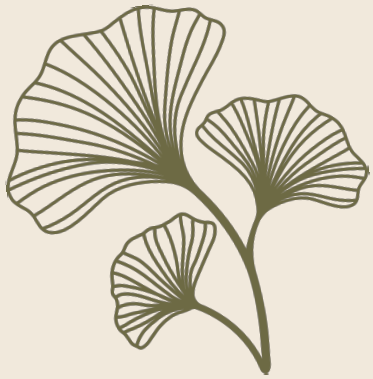
What are your top concerns or goals for your oral health?

Acknowledgement

I have completed this form to the best of my knowledge. I understand that this information will help my dental team provide safe and appropriate care.

SIGN HERE

Date



Thank You for Sharing Your Story

Every patient has a unique story, and we are grateful you've chosen to share yours with us.
Your responses help us understand not only your oral health,
but also the experiences, goals, and priorities that make your care uniquely personal.

We look forward to meeting you, listening carefully,
and partnering with you to support your long-term oral and overall health.

Thank you for trusting us with your care.