We would like to get to know you better!

Date ______________

Name ______________ Date of Birth ______________ Soc. Sec. # ______________

Home Address ______________ City ______________ Zip Code ______________

Phone #: Home ______________ Cell ______________ Work ______________ E-mail ______________

Occupation ______________ Employer ______________ Marital Status ______________

Address ______________

Spouse's Name ______________ Spouse's Occupation ______________ Employer ______________

Address ______________

Whom may we thank for referring you? ______________

Person financially responsible for this account ______________

If you have dental insurance

Name of Ins. Co. ______________ Subscriber's Name ______________

Birth Date ______________ Group No. ______________ Ins. ID/SSN ______________

Medical History

Do you have any general health problems? ______________

Are you currently under a physician's care (reasons) ______________

What, if any, drugs or medications are you currently taking? ______________

To the best of your knowledge, please check any of the below categories that you may ever been afflicte with:

- ☐ Arthritis
- ☐ Cancer
- ☐ Cardiac Pacemaker
- ☐ Diabetes
- ☐ Epilepsy (seizures, fainting)
- ☐ Healing Complications
- ☐ Heart Alignment (including valves)
- ☐ Heart Murmur
- ☐ Heart Valve Defects
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Joint Replacement (Implant)
- ☐ Latex Sensititivty / Allergy
- ☐ Prolonged Bleeding
- ☐ Psychiatric / Psychological Care
- ☐ Respiratory Disease (Sinus Trouble)
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease (Aids)
- ☐ Strokes
- ☐ Thyroid Disease
- ☐ Ulcers

Allergy to any drugs or medications ______________

Are you pregnant, nursing, or taking birth control ______________

Signature ______________

Dental History

Yes No

1. Are your teeth sensitive to :

☐ ☐ Heat?
☐ ☐ Cold?
☐ ☐ Sweets?
☐ ☐ Bitting Pressure?

☐ ☐ 2. Does food constantly get stuck between certain teeth in your mouth?

☐ ☐ 3. Do you get frustrated because you always have somting to be treated or repaired at the Dentist?

☐ ☐ 4. Are you dissatisfied with your teeth in any way?

☐ ☐ 5. Are you dissatisfied with the way your teeth look? for example, color, shape spaces, Etc.?

☐ ☐ 6. Do you have any fillings that show in your front teeth?

☐ ☐ 7. Do any of your fillings show when you smile?

☐ ☐ 8. If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural tooth colored restoration instead?

☐ ☐ 9. Have you ever had teeth removed?

10. How long have these teeth been missing? ______________________

☐ ☐ 11. Do your gums bleed when you brush?

☐ ☐ 12. Do you ever avoid any part of the mouth when brushing?

☐ ☐ 13. Have you ever been instructed regarding proper home care?

☐ ☐ 14. Do you have an unpleasant taste or odor in your mouth?

☐ ☐ 15. Do you smoke?

16. How often do you brush your teeth? ______________________

17. How often do you floss? ______________________

☐ ☐ 18. Have you ever experienced any problems in your jaw such as: pain, clicking, difficulty with opening or closingyour mouth?

☐ ☐ 19. Do you clench or grind your teeth?

☐ ☐ 20. Do you want to learn to control dental disease and retain your teeth?

☐ ☐ 21. Has the fear of discomfort kept you from regular dental visits?

☐ ☐ 22. Are you deeply concerned about the finances required to return your mouth to excellent health?

23. When was your last dental appointment? ______________________

24. What did you have done? ______________________

25. How long since your last thorough examination with full mouth X-Rays? ______________________

26. What prompted you to seek dental care at this time? ______________________

27. Why did you leave your last dentist? ______________________

Remarks: ______________________

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I acknowledge I have received a copy of this office's notice of privacy practices

Patient Signature ______________________ Date ______________________