PLEASE COMPLETE THE FOLLOWING

E-MAIL______________________

GENERAL INFORMATION:

CELLPHONE:______________________

HOME PHONE:______________________

SSN#______________________

Dr.
Mr.
Mrs.
Miss ____
Last **First** **Middle** **Birth Date**

Residence
Address
____
Street **City** **ST** **Zip code**

Business
Addres____(_____)__________
Employer **Street** **City** **ST** **Zip code** **WORK TELEPHONE**

Marital Status__________________ **Name of Spouse**______________________________

Spouse's
Occupation____________________**Employer**______________________________

If Patient is a minor, who is legally responsible**?**______________________________
Name

______________________________________(_____)______________________
Address **Telephone**

By whom were you referred?______________________________When?______________

INSURANCE INFORMATION

Name of Insurance Carrier____

Name of Group Dental Plan ____________________________**Group Number**__________

Employee ______________________________**Employee's SSN #**____________________
Birth Date

Patient ____________________**Relationship to Employee** __________**Patient's Birth Date** __________

Employer____(_____)__________
Address **Telephone**

Has Patient had previous dental care under this plan?______________________________

Is Patient covered by another plan?__________ **If so, name of Plan**______________________

Please turn page over and complete.

MEDICAL HISTORY

Family Physician____**Specialty**______________________________

Address____(____)________________
Telephone

Patient's Height _____________**Weight** ________**Age** _____
Date of last complete Medical Exam________________________

Please encircle YES of NO. If Yes, Please fill in details.

Yes No Do you have a current medical problem? If so, what?____
Yes No Do you have heart trouble? What kind?____
Yes No Have you had rheumatic fever? When?____
Yes No Do you have high or low blood pressure? Is it controlled?____
Yes No Have you had pains in the chest or shortness of breath?____
Yes No Do your ankles swell?____
Yes No Has your physician ever told you that you are anemic?____
Yes No Have you ever had a stroke? If so, When?____
Yes No Have you ever had diabetes? How is it controlled?____
Yes No Are you subject to fainting or dizziness? When?____
Yes No Do you have headaches? How often?____
Yes No Do you have problems with insomnia? How often?____
Yes No Do you have any nervous disorder? How is it controlled?____
Yes No Do you take tranquilizers or sedatives? How often?____
Yes No Do you take aspirin? How often?____
Yes No Are you allergic to any medication? What?____
Yes No Have you been advised not to take any medication? What?____
Yes No Do you have asthma or hay fever? How is it controlled?____
Yes No Have you ever had tuberculosis? When?____
Yes No Have you ever had infectious hepatitis? When?____
Yes No Do you have AIDS or any other immunosuppressive disorders?____
Yes No Do you have arthritis? How is it controlled?____
Yes No Have you ever had a tumor or cancer? How was it treated?____
Yes No Have you had any major operations? What kind?____
Yes No Have you ever been involved in a serious accident?____
Yes No Are you taking any medication at this time? Please List:
Taking____For____
Taking____For____
Taking____For____
Taking____For____
Taking____For____
Taking____For____
Yes No Have you gained or lost weight within the last year? If so, how much?_______________________________________
Yes No Do you become fatigued easily? At what time of the day?____
Yes No Do you routinely eat breakfast? If so, what?____
Yes No Do you drink more that one alcoholic beverage per day? If so, how many?___________________________________
Yes No Do you smoke or use tobacco? If so, how much?____
Yes No Is your diet medically supervised? If so, for what purpose?____

FOR WOMEN
Yes No Are you pregnant? If so, your expected delivery date?____
Yes No Do you have any history of previous miscarriages?____
Yes No Have you reached menopause? If so, are you taking supportive medication?_____________________________________

Please turn page over and complete.

DENTAL HISTORY

Previous Dentist____Speciality__________________________

Address____Telephone(____)______________________

Date of last dental visit________________________,Date of last full mouth X-rays___________________

Date of last complete dental examination____

What is your immediate dental concern?____

How do you feel about the dentistry that you have had in the past?
____

If you could change *anything* about your smile or the appearance of your teeth, what would it be?
____

Please circle YES or NO. If yes, please fill in details.

Yes No Are you presently in any dental pain? ____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _________________________
Yes No Do you have any pain or soreness around your eyes or ears or other parts of your face? ______ When? ____
Yes No Do you ever awaken with an awareness of your teeth or jaws? How often?_________________
Yes No Are you aware of clenching your teeth during your daytime hours? How often?____________
Yes No Have you ever been told you grind your teeth during sleep? How often?___________________
Yes No Are you aware of your jaw clicking or popping while eating or yawning? How often?________
Yes No Do you have difficulty in opening your mouth widely?___________________________________
Yes No Do you have "tension" headaches? How often?____
Yes No Have you lost any teeth? From what cause?____
Yes No Have you ever had orthodontic treatment? When?____
Yes No Do you have any growths or swellings in your mouth? How long have they existed?_________ ____
Yes No Do you have any difficulty in swallowing?____
Yes No Do your gums bleed when brushing your mouth?____
Yes No Do you avoid brushing any part of your mouth? Why?_____________________________________
Yes No Have you ever been told you have pyorrhea? When?_______________________________________
Yes No Is any part of your mouth sensitive to temperature, pressure, food or drink? What?_________ ____
Yes No Do you have a burning sensation in your mouth?____
Yes No Have you ever had a bad reaction to a dental anesthetic? When?__________________________
Yes No Does food catch between your teeth?____
Yes No Do you have an unpleasant taste or odor in your mouth?_________________________________
Yes No Are you satisfied with your teeth and their appearance?______________________________
Yes No Do any members of your family including your parents wear dentures?___________________
Yes No Do you feel you will eventually wear full artificial dentures?___________________________
Yes No Do you think your dental disease is active?____
Yes No Do you want to learn to control your dental disease and retain your teeth?_________________
Yes No Are you deeply concerned about the finances required to return your mouth to excellent dental health?____