1

## About You

	Today's Date:
Name:	
I prefer to be called:	☐ Male ☐ Female
I prefer to be called: Birthdate:/ _/ Age:	SS#:
Home Address:	
City State State Single □ Married □ Divorced	
Hm#: Cell	
Wk#: Ema	
Employer	
Employer's Address:	
How long there?Occupation	
Where & when are the best times to	
Whom may we thank for referring	
Other family members seen by us: _	
Previous/Present Dentist:	
Last Visit Date:	
	Nesting No. 12 (c)
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Are you nursing? 🗆 Yes 🗅 No

## 2 Spouse Information

His/Her Name:	
Employer:	
Wk#: Ext:_	
Birthdate: / / Cell	1#:
Person Responsible for Account	
Wk#: Ext:_	
Billing Address:	
Relation: S	
Employer: (	Cell#:
4 Medic	al Information
Do you have a personal physician	n? □ Yes □ No
Physician's Name	
Phone #: L	
	ency, is there someone who twe should contact?
His/Her Name: R	elation:
Wk#: H	
Y N Aspirin Y N I Y N Codeine Y N I Y N Dental Anesthetics Y N I Please list any other drugs that yo	Penicillin
Have you ever had any of the follo	owing diseases or medical problems
Y N Anemia/Radiation Treatment	Y N Hemophilia/ Abnormal
Y N Arthritis	
Y N Artificial Bones/ Joints	Y N Hepatitis
Y N Artificial Valves	Y N High Blood Pressure
Y N Asthma	Y N HIV+/AIDS
Y N Blood Transfusion	Y N Hospitalized for any reason
Y N Cancer/Chemotherapy	Y N Kidney Problems
Y N Congenital Heart Defect Y N Diabetes - Type	Y N Low Blood Pressure Y N Mitral Valve Prolapse
Y N Difficulty Breathing	Y N Psychiatric Problems
Y N Drug/ Alcohol Abuse	Y N Rheumatic/Scarlet Fever
Y N Emphysema	Y N Severe/Frequent Headaches
Y N Epilepsy/Seizures/Fainting	Y N Shingles
Y N Fever Blisters/ Herpes	Y N Sinus Problems
Y N Heart Attack/Stroke	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers/Colitis
Y N Heart Surgery/Pacemaker	Y N Venereal Disease
Please list any medical cond	ition(s) that you have ever had:

## **Dental History**

1. Any dental needs, discomfort, or requests at this time?  2. When was your last dental examination? 3. When were x-rays last taken of ALL your teeth? 4. Do you use anything besides a brush for dental home care? 5. Anything interfering with regular dental care? Transportation? Anxiety?  Are any of your teeth sensitive to:  Hot or Cold? Yes No Sweets? Yes No Orthodoniic treatment? Yes No Ortho	ame:Last			First Middle		
2. When was your last dental examination?  3. When were x-rays last taken of ALL your teeth?  4. Do you use anything besides a brush for dental home care?  5. Anything interfering with regular dental care? Transportation? Anxicty?  Are any of your teeth sensitive to:  Hot or Cold? Yes No Sweets? Yes No De you frequently get all gores, blisters or any other onal leasons? Yes No De you frequently get all gores, blisters or any other onal leasons? Yes No Have your noticed any loos teeth or change in your brief?  Do your guns bleed or hurt?  Have your parents experienced gun disease or tooth loss? Have your noticed any loos teeths or change in your brief? Yes No Bit your lips or cheeks regularly? Yes No Bit your lips or cheeks regularly? Yes No Mouth breather while awake or asleep? Yes No Mouth breather while awake or aslee				Made		
3. When were x-rays last taken of ALL your teeth?  4. Do you use anything besides a brush for dental home care?  5. Anything interfering with regular dental care? Transportation? Anxiety?  Are any of your teeth sensitive to:  Hot or Cold? Yes No Sweets? Yes No Bitting or Chewing? Yes No Do your feed any mouth odors or bad tastes? Yes No Do your feed any mouth odors or bad tastes? Yes No Periodonal treatment? Yes No Periodonal treatment? Yes No A bite plate or mouth goard? Yes No A bite plate or mouth goard? Yes No Have your noticed any loose teeth or change in your bite? Have your parents experienced gum disease or tooth loss? Have your noticed any loose teeth or change in your bite? Possible for poying of the jaw? Yes No Have your noticed any loose teeth or change in your bite? Yes No Bite your lips or cheeks regularly?  Do you:  Clench or grind your teeth while awake or asleep? Yes No Bite your lips or cheeks regularly? Yes No Hold foreign objects with your teeth? (pencils, pipe, pins, nalls, fingernails) Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tred jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No The possible for paying any co-payment and deductibles that my insurance does to cover.  Co payment/Payment is due in full at the time of tre Unless pro arrangement have been approach to cover.  Dote the best of my knowledge. I also understand that this information that I have given today is correct ofform this office of any changes in my medical status.  Some payment/Payment is due in full at the time of tre Unless pro arrangement have been approach to cover.  Co payment/Payment is due in full at the time of the propring any co-payment and deductibles that my insurance does the payment of the propring any co-payment and deductibles that my insurance does infection cort	III at talkens					
4. Do you use anything besides a brush for dental home care?  5. Anything interfering with regular dental care? Transportation? Anxiety?  Are any of your teeth sensitive to:  Hot or Cold? Yes No Sweets? Yes No Biting or Chewing? Yes No Do you frequently get cold sores, blisters or any other oral lesions?  Do you frequently get cold sores, blisters or any other oral lesions? Yes No Do your gums bleed or hurt? Have your noticed any loose teeth or change or tooth loss? Have your noticed any loose teeth or change or tooth loss? Have your noticed any loose teeth or change in your bite?  Does food tend to become caught in-between your teeth? Yes No Bite your lips or cheeks regularly? Yes No Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernals) Yes No Mouth breathe while awake or asleep? Yes No Smoke/chew tobacco? Yes No Smo	2. When was your last dental examination?	18 th				
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Biting or Chewing? Yes No Sweets? Yes No Biting or Chewing? Yes No Do you frequently get cold sores, blisters or Do you frequently get cold sores, blisters or Do your grams bleed or hurt? Have your parents experienced gum disease or tooth loss? Have your noticed any loose tech or change in your bite? Does food tend to become caught in-between your teeth? Yes No Bitte your lips or cheeks regularly? Yes No Bitte your lips or cheeks regularly? Yes No Mouth breath while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Mouth breath while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Mouth breath while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Mouth breath while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especi						
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A bite plate or mouth guard? Yes No Do your gums bleed or hurt? Have your parents experienced gum disease or tooth loss? Have your noticed any loose teeth or change in your teeth? If yes, where?  Does food tend to become caught in-between your teeth? If yes, where?  Do you:  Clench or grind your teeth while awake or asleep? Yes Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Mouth breathe while awake or asleep? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes, please describe  Are you satisfied with your teeth all of your life? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes, please describe  Are you satisfied with your teeth all of your life? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes, please describe  Are you satisfied with your teeth all of your life? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tired jaws, especially in the morning? Yes No Have tir	Have you noticed any mouth odors or bad tastes?	Yes				
As erious injury to the mouth or head? If so, please describe, including cause  Have your parents experienced gum disease or tooth loss? Have your noticed any loose teeth or change in your bite? Does food tend to become caught in-between your teeth? If yes, where?  Does food tend to become caught in-between your teeth? If yes, where?  Do you:  Clench or grind your teeth while awake or asleep? May be a place of the compact of the pool of the place of the	Do you frequently get cold sores, blisters or					
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Have your noticed any loose teeth or change in your bite?  Does food tend to become caught in-between your teeth?  If yes, where?  Do you:  Clench or grind your teeth while awake or asleep?  Hold foreign objects with your teeth?  (pencils, pipe, pins, nails, fingernails)  Mouth breathe while awake or asleep?  Have tired jaws, especially in the morning?  Smoke/chew tobacco?  Smoke/chew tobacco?  There anything else about having dental treatment that you would like us to know?  Are you satisfied with your teeth all of your life? You you feel nervous about having dental treatment? If yes, please describe  Have you experienced:  Clicking or popping of the jaw? Yes No Pain (joint, ear, side of face)  No Would you like to keep all of your teeth all of your teeth all of your teeth all of your teeth ear.  Would you like to keep all of your teeth ear.  If yes, please describe  If yes, please describe  If yes, please describe  Co payment/Payment is due in full at the time of treatment have been approved.  Co payment/Payment is due in full at the time of treatment have been approved.  Co payment/Payment is due in full at the time of treatment have been approved.  Co payment/				is so, preuse desertoe, including cause		
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If yes, where?  Do you:  Clench or grind your teeth while awake or asleep?  Bite your lips or cheeks regularly?  (pencils, pipe, pins, nails, fingernails)  Mouth breathe while awake or asleep?  Have tired jaws, especially in the morning?  Smoke/chew tobacco?  Wes No  Smoke/chew tobacco?  Smoke/chew tobacco?  Mere anything else about having dental treatment that you would like us to know?  Thank you for filling out this form completely. It will be held in the strictest confidence and it is my responsibile for paying any co-payment and deductibles that my insurance does  OFFICE USE ONLY  OFFICE U	Have your noticed any loose teeth or change	168	110	Have you experienced:		
Does food tend to become caught in-between your teeth? Yes No If yes, where?  Do you:  Clench or grind your teeth while awake or asleep? Mould foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Mouth breathe while awake or asleep? Yes No Have tired jaws, especially in the morning? Smoke/chew tobacco? Yes No Smoke/chew t			No	Clicking or popping of the jaw?	Yes	1
If yes, where?  Do you:  Clench or grind your teeth while awake or asleep? Bite your lips or cheeks regularly? Yes No Bite your lips or cheeks regularly? Yes No Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have given today is correct the best of my knowledge. I also understand that this information that I have given today is correct the best of my knowledge. I also understand that this information form this office of any changes in my medical status.  Co payment/Payment is due in full at the time of treduced in the strictest confidence and it is my responsibility to form this office of any changes in my medical status.  Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any question time, please ask us. We are happy to he standards infection control mandated by OSHA, the CDC and the ADA.  Our office is committed to meeting or exceeding the standards infection control mandated by OSHA, the CDC and the ADA.  OFFICE USE ONLY OFFICE USE O	Does food tend to become caught in-between	103	110	Pain (joint, ear, side of face)	Yes	1
If yes, where?  Do you:  Clench or grind your teeth while awake or asleep? Yes No Bite your lips or cheeks regularly? Yes No Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No Mouth breathe while awake or asleep? Yes No Mouth breathe while awake or asleep? Yes No Mouth breathe while awake or asleep? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Smoke/chew tobacco? Yes No Have tired jaws, especially in the morning? Yes No Smoke/chew tobacco? Yes No Have given today is correct the best of my knowledge. I also understand that this information Ib be held in the strictest confidence and it is my responsibility to form this office of any changes in my medical status.  Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any question time, please ask us. We are happy to help.  Our office is committed to meeting or exceeding the standards infection control mandated by OSHA, the CDC and the ADA.  OFFICE USE ONLY			No	Difficulty in opening or closing the mouth?	Yes	1
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