We would like to get to know you better!

Date: _____ Male ☐ Female ☐

Name: _____
Address: _____
City, State, Zip: _____
Email:_____
Phone:_____
Cell: _____
Work: _____
Parent's Name, if under 18: _____
Date of Birth: _____
Age: _____ SSN: _____

Employer: _____
Address:_____
Phone: _____
Spouse's Name_____
Spouse's Employer_____
Insurance Information:
Policy Holder: _____
Date of Birth:_____
SSN: _____
Secondary Insurance? _____

Who referred you to our office? _____
Person responsible for dental investment: _____

Are your teeth sensitive to:	Yes	No
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Problems of the jaw:		
Clicking of the jaw	☐	☐
Pain (joints, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
Headaches	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐
Have you had a reaction to a local anesthetic?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐
Are you deeply concerned about the finances required to return your teeth to excellent dental health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Do you smoke?	☐	☐
Have you ever had any teeth removed?	☐	☐
How long have these teeth been missing? _____		
Do you feel you will eventually wear dentures?	☐	☐
Do you have any fears concerning dental treatment?	☐	☐
When was your last dental appointment?		
_____		
	Yes	No
Do you have any general health problems?	☐	☐
If so, please specify _____		
_____		

Have you had a joint replacement or any other surgery? ☐ ☐
If so, please specify?_____
_____

Are you currently under a physician's care? ☐ ☐
Reason _____
_____

Any medications? ☐ ☐
_____

To the best of your knowledge, are you are have you ever been afflicted with:	Yes	No
Heart Ailment	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease	☐	☐
Hepatitis	☐	☐
HIV Positive	☐	☐
Prolonged Bleeding	☐	☐
Healing Complications	☐	☐
Positive TB Test	☐	☐

Allergy to any drug? ☐ ☐
_____
_____

Are you pregnant? ☐ ☐
Month _____

Why did you leave your last dentist?
_____
_____

What is your present dental problem?
_____
_____

Signature:_____