We would like to get to know you better!

Name: _____ Male ❑ Female ❑ Date: _____
Residence: _____ Zip Code: _____
If child; Parent name: _____
Phone: _____ Occupation: _____ Employer: _____
Employer Address: _____ Employer Phone: _____
Date of Birth: _____ Age: _____ Spouse's Name: _____
Spouse's Occupation: _____ Spouse's Employer: _____
Employer Address: _____ Employer Phone: _____
Who referred you to our office? _____
Person responsible for dental investment: _____

For Insurance Purposes:
Name of Carrier: _____
Social Security Number: _____ Group Number: _____
Are you covered by another plan? _____ If so, Name of Carrier: _____
Social Security Number: _____ Group Number: _____

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	❑	❑
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 & 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 artificial dentures?	❑	❑
Do you have any fears?	❑	❑

	Yes	No
When was your last dental appointment? _____		
Do you have any general health problems?	❑	❑
If so, please specify: _____		
_____		
Have you had surgery?	❑	❑
If so, please specify: _____		
_____		
Are you currently under a physician's care?	❑	❑
Reason: _____		
Any Medications? _____		
To the best of your knowledge, are you or have you ever been afflicted with:		
Heart Ailment _____	❑	❑
Diabetes	❑	❑
Rheumatic Fever	❑	❑
Epilepsy	❑	❑
High Blood Pressure	❑	❑
Respiratory Disease	❑	❑
Hepatitis	❑	❑
HIV Positive	❑	❑
Prolonged Bleeding	❑	❑
Healing Complications	❑	❑
Allergy to any Drug	❑	❑
Are you pregnant?	❑	❑
Why did you leave your last dentist? _____		
_____		
What is your present dental problem? _____		
_____		

Signature: _____