

## 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: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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: \_\_\_\_\_

<p>Are your teeth sensitive to:</p> <p style="padding-left: 20px;">Heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Cold? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Biting Pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does food catch between your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your gums bleed when brushing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you noticed any gum swelling around any teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have an unpleasant taste or odor in your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems of the Jaw:</p> <p style="padding-left: 20px;">Clicking of the jaw <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Pain (joints, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Difficulty opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Difficulty chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you ever avoid any part of the mouth while brushing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had a reaction to a local anesthetic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you dissatisfied with your teeth &amp; their appearance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you deeply concerned about the finances required to return your teeth to excellent dental health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had any teeth removed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How long have these teeth been missing? _____</p> <p>Do you feel you will eventually wear artificial dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any fears? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>When was your last dental appointment? _____</p> <p>Do you have any general health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, please specify: _____</p> <p>_____</p> <p>Have you had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, please specify: _____</p> <p>_____</p> <p>Are you currently under a physician's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Reason: _____</p> <p>Any Medications? _____</p> <p>To the best of your knowledge, are you or have you ever been afflicted with:</p> <p style="padding-left: 20px;">Heart Ailment _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Prolonged Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Allergy to any Drug <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Why did you leave your last dentist? _____</p> <p>_____</p> <p>What is your present dental problem? _____</p> <p>_____</p>
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Signature: \_\_\_\_\_