

PLEASE COMPLETE THE FOLLOWING
(PLEASE PRINT OR TYPE)

GENERAL INFORMATION

Dr. _____ Date _____
 Mr. _____
 Mrs. _____ Birthdate _____
 Miss _____
 Ms. _____
Last, First, Middle

Residence Address _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

If less than one year, your previous address _____
Number, Street, City, State, Zip Code

Marital Status _____ Social Security No. _____ Driver's license No. _____

Occupation _____ Employer _____

Address of Employer _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

Name of Spouse _____ Spouse's Social Security No. _____

Occupation _____ Employer _____

Address of Employer _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

If patient is a minor, who is legally responsible? _____

Address _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

By whom were you referred? _____ When? _____

INSURANCE INFORMATION

If you have any type of dental insurance, please complete the following. If not, turn the page.

Name of Insurance Carrier _____

Name of Group Dental Plan _____ Group No. _____

Employee's Name _____ Employee's Social Security No. _____

Patient _____ Relationship to employee _____ Employee's Birthdate _____

Employer _____

Address of Employer _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

Union Local Name _____ Union Local No. _____

Address of Union _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

Has the patient had previous dental care under this plan? ___ If yes, when? _____

Is the patient covered by another plan? _____ If yes, Name of the Plan _____

Employer _____

Address of Employer _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

Please be sure to obtain a copy of the Office Policy regarding Insurance Programs

PLEASE TURN THE PAGE

MEDICAL HISTORY

Family Physician _____ Specialty _____

Address _____
Number Street City State Zip Code Area Code - Telephone

Additional Physician _____ Specialty _____

Address _____
Number Street City State Zip Code Area Code - Telephone

Height _____ Weight _____ Age _____ Date of last complete medical examination _____

Please encircle **YES** or **NO**. If YES, please fill in details.

Yes No Do you have a current medical problem? 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 ever swell? _____

Yes No Has your physician ever told you that you are anemic? _____

Yes No Have you ever had a stroke? 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 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? 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? How much? _____

Yes No Do you become fatigued easily? At what time of day? _____

Yes No Do you routinely eat breakfast? What? _____

Yes No Do you take more than one alcoholic drink per day? How many? _____

Yes No Do you use tobacco? How much? _____

Yes No Is your diet medically supervised? For what purpose? _____

FOR WOMEN

Yes No Are you pregnant? 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? _____

DENTAL HISTORY

Previous Dentist _____ Period of Treatment _____ Specialty _____

Address _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

Other Dentist _____ Period of Treatment _____ Specialty _____

Address _____ Telephone _____
Number, Street, City, State, Zip Code Include Area Code

Last dental visit? _____ Last full-mouth x-ray? _____ Last complete dental exam _____

What is your immediate dental concern? _____

Please encircle **YES** **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? _____
What? _____

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? _____

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 pain or soreness around your eyes, ears or other parts of your face? _____
When? _____

YES NO Are you aware of stiff neck muscles? How often? _____

YES NO Do you ever awaken with awareness of your teeth or jaws? How often? _____

YES NO Are you aware of clenching your teeth during 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 Do you have an unpleasant taste or odor in your mouth? _____

YES NO Are you dissatisfied with your teeth and their appearance? _____

YES NO Do you feel you will eventually wear full artificial dentures? _____

YES NO Do any members of your family including your parents wear 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? _____

YES NO Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? _____

SUPPLEMENTAL DENTURE HISTORY

If you wear a partial or complete artificial denture, please complete the following:

For what reason were your teeth lost? _____

When did you receive your first partial or complete denture? _____

Approximate date of extractions: _____

Was your first complete denture placed the same day the teeth were extracted? _____

How many complete or partial dentures have you had? Upper? _____ Lower? _____

How long have you worn your present denture? _____

Has it been relined? _____

Your last denture was constructed by: _____

What is your present denture problem? _____

Are you satisfied with the appearance of your dentures? _____

Are you satisfied with the comfort of your dentures? _____

Are you satisfied with the chewing ability? _____

Do you wear your dentures 24 hours a day? _____ If not, why not? _____

Do you bite your tongue or cheek with your dentures? _____

Do your dentures click during speech? _____

Is your speech influenced by your dentures? _____ How? _____

What do you expect of your new denture? _____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his/her Staff, and assume financial responsibility.

Signature _____ Date _____

Please be sure to obtain a copy of the Office Policy regarding financial arrangements.