DATE ______________________________

LAST NAME | DR., MR, MRS, MS. | FIRST NAME | MIDDLE

NAME YOU GO BY | NAME OF SPOUSE

HOME ADDRESS | CITY | STATE / ZIP | CELL/ HOME PHONE NO.

EMPLOYER | BUSINESS ADDRESS | OFFICE PHONE NO. | SOCIAL SECURITY NO.

EMAIL ______________________________

1. **WHO MAY WE THANK FOR REFERRING YOU?** ______________________________
2. **WHAT IS YOUR PRESENT DENTAL CONCERN?** ______________________________

DENTAL HISTORY

1. **HAVE YOU LOST ANY OF YOUR NATURAL TEETH?** ❑ YES ❑ NO HOW? ______________________________
2. **HAVE THEY BEEN REPLACED?** ❑ YES ❑ NO HOW? ______________________________
3. **DATE AND TYPE OF LAST DENTAL X-RAYS?** ______________________________
4. **HOW WOULD YOU RATE YOUR PRESENT DENTAL HEALTH?** ❑ EXCELLENT ❑ GOOD ❑ POOR
5. **HOW WOULD YOU LIKE TO RATE YOUR FUTURE DENTAL HEALTH?** ❑ EXCELLENT ❑ GOOD ❑ POOR
6. **ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?** ❑ YES ❑ NO ❑ IF NOT, WHY? ______________________________

7. HAVE YOU NOTICED:	YES	NO
A. GROWTHS, SWELLING, SORE SPOTS	❑	❑
B. PAIN OR TENDERNESS IN YOUR TEETH	❑	❑
C. BLEEDING GUMS	❑	❑
D. SENSITIVE TEETH	❑	❑
E. FOOD CATCHING BETWEEN TEETH	❑	❑
F. BAD BREATH	❑	❑

8. GENERAL DENTAL INFORMATION:	YES	NO
A. HAVE YOU BEEN SHOWN HOW TO FLOSS YOUR TEETH?	❑	❑
B. HAVE YOU BEEN TREATED FOR GUM DISEASE?	❑	❑
C. HAVE YOU HAD BRACES TO STRAIGHTEN YOUR TEETH?	❑	❑
D. DO YOU HAVE DIFFICULTY IN SWALLOWING?	❑	❑

9. **PROBLEMS WHICH MAY BE RELATED TO YOUR OCCLUSION (BITE) OR JAW JOINT. HAVE YOU HAD, OR BEEN AWARE OF:**

	YES	NO
A. TIRED FEELING IN FACE WHILE CHEWING	❑	❑
B. RINGING OR PAIN IN EAR	❑	❑
C. PAIN AROUND EARS, EYES, NECK, HEAD	❑	❑
D. CLENCHING OR GRINDING YOUR TEETH	❑	❑
E. HEADACHES	❑	❑
F. POPPING NOISES IN THE JAW JOINT	❑	❑

10. **WHICH ITEMS DO YOU USE REGULARLY?** ❑ HAND TOOTHBRUSH ❑ DENTAL FLOSS ❑ ELECTRIC TOOTHBRUSH ❑ WATER SPRAY ❑ TOOTHPICKS, STIMULATORS , ETC. ❑ RUBBER TIP ❑ Other ______________________________
11. **HAVE YOU HAD ANY UNFAVORABLE DENTAL EXPERIENCES?** ❑ YES ❑ NO ______________________________
12. **DO YOU DESIRE TO MAINTAIN YOUR OWN TEETH AND AVOID DENTURES AS LONG AS POSSIBLE?** ❑ YES ❑ NO
13. **HOW IMPORTANT IS IT TO YOU TO KEEP YOUR NATURAL TEETH?**

VERY IMPORTANT 10 9 8 7 6 5 4 3 2 1 NOT IMPORTANT AT ALL

MEDICAL HISTORY

FAMILY PHYSICIAN ____ SPECIALTY ____ ADDRESS ____ TELEPHONE ____

HEIGHT______________ WEIGHT______________ AGE______________ DATE OF BIRTH ______________________________

DATE OF LAST MEDICAL EXAM ______________________________(MONTH / YEAR)

1. **HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?** ❑ POOR ❑ FAIR ❑ GOOD
2. **HOW WOULD YOU DESCRIBE YOUR DIET?** ❑ POOR ❑ FAIR ❑ GOOD
3. **DO YOU EXERCISE REGULARLY?** .... ❑ YES ❑ NO
4. **DO YOU SMOKE?** .... ❑ YES ❑ NO **IF YES, DOES IT CONCERN YOU?** .... ❑ YES ❑ NO
5. **DO YOU TAKE MORE THAN ONE ALCOHOLIC DRINK PER DAY?** ❑ YES ❑ NO
6. **ARE YOU NOW BEING TREATED OR HAVE YOU BEEN TREATED WITHIN THE LAST YEAR BY A PHYSICIAN?** ❑ YES ❑ NO
   FOR WHAT? ....
7. **HAVE YOU EVER HAD AN UNUSUAL REACTION TO DENTAL ANESTHESIA (GAS OR SHOTS)?** ❑ YES ❑ NO
8. **FOLLOWING INJURIES OR DENTAL TREATMENT, HAVE YOU HAD BLEEDING PROBLEMS?** ❑ YES ❑ NO
9. **IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?** ❑ YES ❑ NO
10. **ARE YOU THIRSTY MOST OF THE TIME?** .... ❑ YES ❑ NO
11. **HAVE YOU RECENTLY LOST OR GAINED WEIGHT UNINTENTIONALLY?** .... ❑ YES ❑ NO
12. **IF DIAGNOSED AS A DIABETIC, ARE YOU CURRENTLY TAKING MEDICATION?** .... ❑ YES ❑ NO

HAVE YOU BECOME SICK FROM, SHOWN AN ALLERGY TO, OR BEEN TOLD NOT TO TAKE:

13. ❑ ANTIBIOTICS (penicillin , etc.)
14. ❑ CODEINE
15. ❑ NOVOCAINE OR OTHER DENTAL ANESTHESIA
16. ❑ OTHER DRUGS OR MEDICINES______________________________

ARE YOU NOW TAKING OR USING MEDICINE FOR:

17. ❑ NERVES (tranquilizers)
18. ❑ SLEEPING
19. ❑ HEART OR BLOOD PRESSURE (digitalis, nitroglycerin, reserpine)
20. ❑ BLOOD (liver or iron pills, etc.)
21. ❑ STOMACH TROUBLE (ulcer or other)
22. ❑ HEADACHES
23. ❑ ARTHRITIS OR RHEUMATISM
24. ❑ ALLERGY

ARE YOU NOW:

25. ❑ PREGNANT
26. ❑ ON A PRESCRIBED DIET
27. ❑ USING THYROID MEDICATION
28. ❑ USING HORMONES (including birth control pills)
29. ❑ USING ANTICOAGULANTS
30. ❑ USING DILANTIN
31. ❑ USING OTHER MEDICINES______________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

32. ❑ HEART DISEASE
33. ❑ SHORTNESS OF BREATH WITHOUT EXERCISE OR WHEN LYING DOWN
35. ❑ SWELLING OF ANKLES OR FEET
36. ❑ PAIN, PRESSURE, OR TIGHT FEELING IN CHEST
37. ❑ HEART ATTACK
38. ❑ MITRAL VALVE PROLAPSE
39. ❑ RHEUMATIC FEVER
40. ❑ HIGH BLOOD PRESSURE
41. ❑ FAINTING SPELLS, CONVULSIONS, EPILEPSY
42. ❑ FREQUENT HEADACHES (two or three a week)
43. ❑ NERVOUS BREAKDOWN, PSYCHOTHERAPY
44. ❑ LUNG TROUBLE (TB, asthma, emphysema)
45. ❑ HEPATITIS, LIVER DISEASE, JAUNDICE
46. ❑ ACQUIRED IMMUNODEFICIENCY SYNDROME
47. ❑ ARTHRITIS, SORE JOINTS
48. ❑ EXCESSIVE BLEEDING
49. ❑ BLOOD TROUBLE, ANEMIA, LEUKEMIA
50. ❑ X-RAY, RADIUM OR COBALT TREATMENTS
51. ❑ JOINT REPLACEMENTS

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SIGNATURE DATE

FOR OFFICE USE ONLY____