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: __________

	Yes	No
Are your teeth sensitive to:		
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: ______________________