Yasaman S. Roland D.D.S. Annapolis, Maryland 410-266-3595

WE WOULD LIKE TO GET TO KNOW YOU BETTER!

DATE	
NAME	
RESIDENCE	
PHONE	
OCCUPATION	
EMPLOYER	
ADDRESS	
PHONE	
DATE OF BIRTH	
MARITAL STATUS	
SPOUSE'S NAME	
SPOUSE'S OCCUPATION	
EMPLOYER	
ADDRESS	
PHONE	

WHOM MAY WE THANK FOR REFERRING YOU?

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

Do you have a dental benefit plan?_____ If yes, carrier_____

DENTAL HISTORY

(Please fill in the following)

Are your teeth sensitive to:

0	Heat?
0	Cold?
0	Sweets?
0	Biting Pressure?

Does food constantly get stuck between certain teeth in your mouth?

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?

Are you dissatisfied with your teeth In any way?

Are you dissatisfied with the way your teeth look? For example: color,

Do you have any fillings that show in your front teeth?

Do any of your fillings show when you smile?

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth- colored restoration instead?

Have you ever had any teeth removed?

How long have these teeth been missing?_

YES	NO





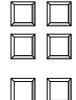
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Do your gums bleed when brushing?

Do you ever avoid any part of the mouth while brushing?



Have you been instructed regarding proper home care?		
Do you have an unpleasant taste or odor in your mouth?		
Do you smoke?		
Do you frequently snack between Meals on sweets or chew gum?		
How often do you brush your teeth?		
How often do you use floss?		
Do you want to learn to control dental disease and retain your teeth?		
Has the fear of discomfort kept you from regular visits?		
Are you deeply concerned about the finances required to return your mouth to excellent dental health?		
When was your last dental appointment?		
What did you have done?		
How long since your last thorough examination with full mouth x-rays?		
What prompted you to seek dental care at this time?		

REMARKS

MEDICAL HISTORY

	YES NO	
Do you have any general health problems?		
If so, please specify		
Are you currently under a physician's care? Reason Name and Address of Physician		
Are you currently taking any drugs or medication?		
If so, what?		
To the best of your knowledge, are you or have you ever been afflicted with:		
Heart AilmentDiabetesRheumatic FeverEpilepsyHigh Blood PressureRespiratory DiseaseHepatitisProlonged BleedingHealing ComplicationAllergy to any DrugsWould you like us to take yourblood pressure?		
blood pressure?		
Why did you leave your last dentist?		

SIGNATURE_____