Today's Date_____

Patient Name_____ Male/Female Birth date_____
Daytime #_____ Cell#_____ WK #_____
Address_____City_____State_____Zip_____
Employer_____ Ins Co./Phone#_____ Group #_____
Social Security#_____
****

Spouse_____ Ins Co./Phone# _____Group#_____
Social Security#_____ Work Phone #_____Date of Birth_____
****

Who is responsible for Account _____
Person to contact for Emergency_____ Phone #_____
Are other members of your family patients at our office Yes____ No____
Names:_____ You were referred to us by_____
****

Dental History

What is the reason for your visit today?_____
Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Complete Exam_____
How often do you brush?_____ How often do you floss?_____
Have you ever used or are currently using topical fluoride? Yes No
What other dental aids do you use? (Interplak, toothpick, etc.) _____
Do you have any dental problems now? Yes No
If yes, please describe_____
How do you feel about losing your teeth? _____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Do you get cold sores?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food get caught in your teeth?	Yes	No

Do you:		
Clench or grind your teeth?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(Pencils,pipe,pins,nails,fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have other sleeping disorders?	Yes	No
Smoke/chew tobacco products?	Yes	No
Need premedication before treatment?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or adjusted?	Yes	No
A serious injury to mouth or head?	Yes	No

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint,ear,side of face)	Yes	No
Difficulty in opening or closing mouth?	Yes	No
Difficulty chewing?	Yes	No
Headaches, neckaches, or shoulder aches?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No