Last Name: _____ First Name: _____ Name of Spouse: _____ Referred By: _____

Address: _____ City, State, Zip: _____ Home Phone: _____ Employer: _____

Dental Insurance: _____ Social Security No.: _____ Group No.: _____ Bus. Address: _____

When was your last complete physical examination: _____ Birth date: _____ Weight: _____ Bus. Phone: _____

Are you under the care of a physician now? _____ For what reason: _____

Are you receiving any medication? _____ What? _____

Do you have excessive bleeding from a cut? _____

Have you ever had radiation treatment? _____ Anemia? _____ Diabetes? _____

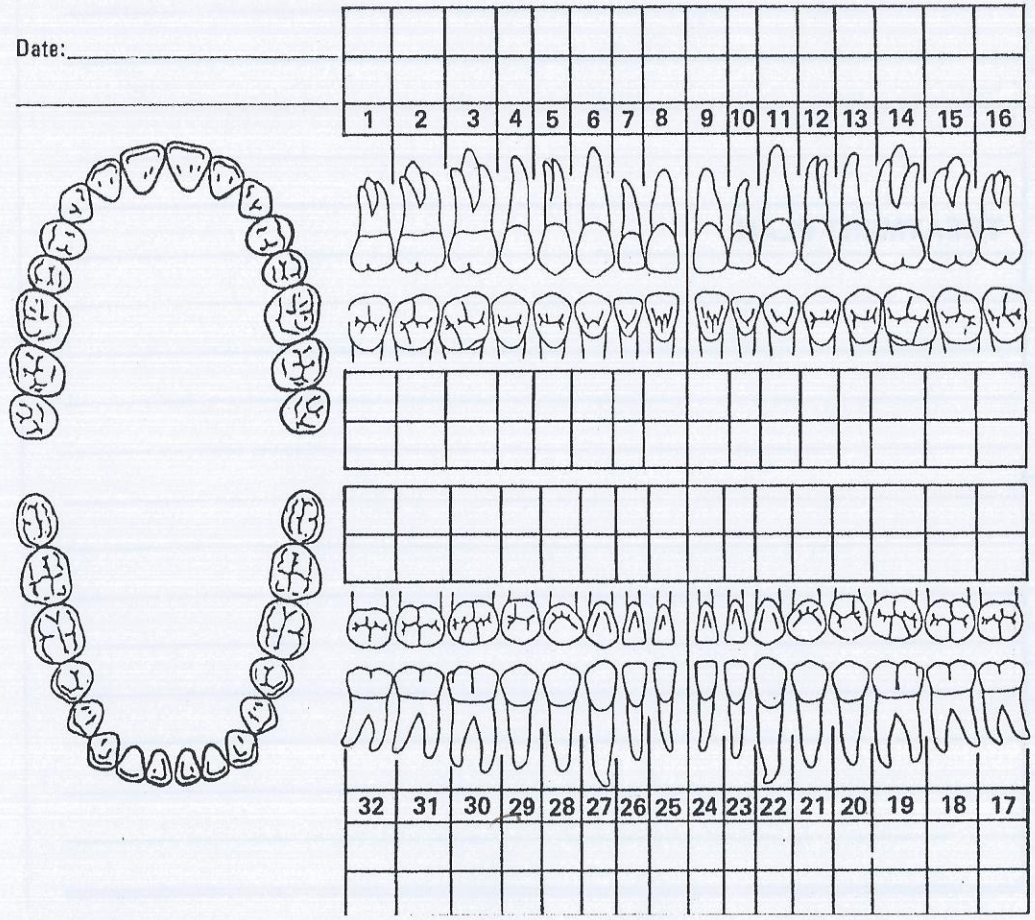
Do you have any allergies? _____ To Penicillin? _____ To Novocain? _____ To Food? _____

Arthritis? _____ Rheumatic Fever? _____ Abnormal Blood Pressure? _____ Heart Condition? _____

Have you ever had Hepatitis? _____ T.B.? _____ Comments: _____

WOMEN – Are you pregnant? _____

Date: _____



ORAL HEALTH

How long since you've been to a dentist: _____ What was done then: _____

Did you have X-rays: _____ Did you regularly visit the dentist before then: _____

Have you lost many teeth: _____ Why? _____

Were there any complications with the extractions? _____

Have they ever been replaced by: A fixed bridge ☐ A removable partial ☐ A denture ☐

How long do you use a toothbrush before replacing it? _____

Do you use dental floss? _____ How often: _____

Between the Teeth Stimulator: _____ Water Pick: _____

Do you have bleeding gums? _____ When? _____

Do you eat between meals? _____ Do you brush teeth after snacks? _____

Does food wedge between your teeth? _____ Where? _____

Are you aware of any broken and/or cracked fillings? _____

Do you grind or clench your teeth? _____ When? _____

Have you ever had gum treatments? _____ When? _____

Do you eat sweets? _____ Raw Vegetables? _____

Do you feel you may have bad breath at times? _____

Unpleasant taste in mouth? _____ Any pain in or around your ears? _____

Do you hear popping, clicking or snapping noises when you chew? _____

Do you have any nasal obstruction? _____

Are you aware of any swelling or lump in your mouth? _____

Do you have any of these habits? Thumbsucking ☐ Fingersucking ☐

Cheek or Tongue Chewing ☐ Pencil Chewing ☐ Pens ☐ Lips ☐ Fingernails ☐

Do you fear dentistry being done? _____ If yes, why? _____

How do you feel about your teeth? _____

How do you feel about dentures? _____

Do you want to avoid the dental discomfort you've had in the past? _____

NAME of PHYSICIAN: _____

TELEPHONE NUMBER: _____