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: ______________________
email:

For Insurance Purposes:
Name of Carrier: ______________________ DOB: __________
Social Security Number: __________ Group Number: __________
Are you covered by another plan? __________ If so, Name of Carrier: __________
Social Security Number: __________ Group Number: __________

Are your teeth sensitive to:	Yes	No
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?	☐	☐

When was your last dental appointment? __________	Yes	No
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: ______________________