TO BE COMPLETED BY PATIENT

PERSONAL HISTORY

Name _____ Nickname _____ Today's Date _____

Date of Birth _____ Sex M ___ F ___ Social Security # _____

Home Phone _____ Business Phone _____

E-Mail _____ Cell Phone _____ Fax _____

Home Address _____ City _____ Zip _____

Billing Address _____ City _____ Zip _____

Business Address _____ City _____ Zip _____

Occupation _____ Employer _____

Dental Ins. Yes ____ No ___ Dental Ins. Co. _____

Marital Status _____ Physician Name & Phone _____

In Case of Emergency, Who should be notified? _____ Phone _____

Referred By _____ Signature _____

DENTAL HISTORY

Reason for this visit _____

Date of last dental visit _____ What services were done? _____

Have you ever experienced prolonged bleeding following a tooth extraction? _____

Have you ever experienced dizziness or fainted during dental treatment? _____

Have you ever experienced difficulty with dental anesthetic ("Novocaine")? _____

Are any teeth sensitive to hot, cold,sweets, or biting? _____

Do you have: Bleeding gums? _____ Frequent blisters in mouth? _____

Swelling or lumps in mouth? _____ Food impactions? _____

Cheek biting? _____ Clenching or grinding teeth _____

Clicking, popping, or difficulty opening or closing jaw? _____

How often do you brush? _____ Do you floss? _____

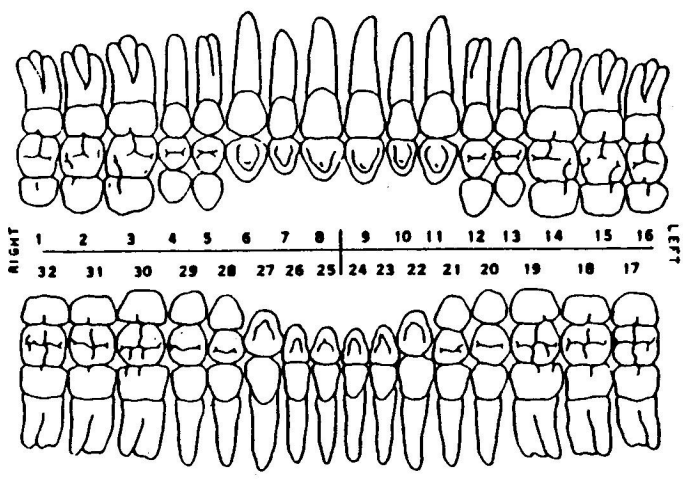
Have you had any unpleasant dental experiences? _____

How do you feel about your teeth in general? _____

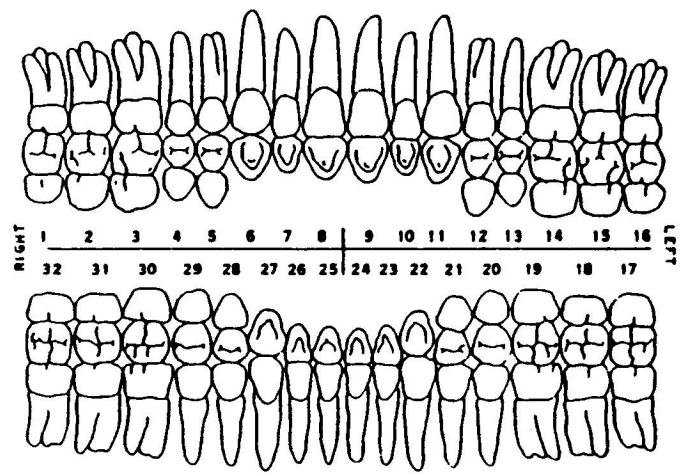
Are you happy with the appearance of your teeth? _____

OFFICE USE

Missing Teeth, Existing Restorations and Decay



Planned Treatment and Subsequent Restorations



COMMENTS