Patient's	Name	First		Middle			Las	st	
Name of	Spouse	First		Middle			Las	×+	
Residen	ce Address	riist		ivildale			Las	51	
		Street		City			Zip		
Employe	Name			Address		Pi	none	How Long?	
Spouse's	s Employer			0 d due -		Di	none	How Long?	
Your Occupation		H	ome Phone	Address		Cell Pho		How Long?	
Date of Birth		Email Address:					Social Security #		
Date of Birth		Email Address.			-		Gooda Goodany II		
Patient's Physicia	an					Physicia	n's Phone		
How long has it been since your last physical?				FOR OFFICE USE ONLY					
-				SOFT TISSUE/ORAL CANCER BITE & JOINT					
	Are you under medical treatment now?				EXAMINATION  Any quelling			EXAMINATION  Noises, pain	
For what are you being treated?								Excessive wear	
Medications you	Drug	Purpose			Tori Class I				
J. W. P. C.					istulasbnormal frenum				
				Papillary inflamma			Grinding, clenchir		
				Perio pockets			Crossbite		
				Salivary glands					
	hospitalized for any surgical		illness	Tongue thrust  Mouth breather			Diasternas		
	5 years?			Salivary problems					
If yes, please ex	xplain			Gag reflex					
				Pain threshold Lesions, cysts					
				Abnormal growths					
Has your health changed in the past year?				Lymph nodes					
Do you smoke	or use tobacco in any form?			Gingiva ( Good Edema					
Women only: Are you pregnant? Nursing?			Color						
	Taking oral contraceptives	?		Recession					
Y/N Y/N	ergic to or have you I Any metals (nickel, mercu Aspirin, lbuprofen	ıry,) Y / N Y / N	n to the fo Erythromyci lodine		Y/N Se Y/N Si	ulfa Drug		HEALTH	
	Codeine, Narcotics Dental Anesthetics	Y / N Y / N	Latex Penicillin		Y/N Te Y/N O		ie	UPDATE	
Do vou rea	uire any pre-medicat	tion?Fo	or what pu	urpose?	TAL STATE		4000		
-	ve or have you had a								
Y/N	Alcohol, drug abuse Anemia	rs	Y/N M Y/N Pa						
Y/N	Angina	Y/N	Glaucoma Hay fever, a		Y/N Ps	sychiatric	Treatment		
	Y / N Arthritis Y / N Heart Attacl Y / N Artificial valves Y / N Heart Murm		ur Y/N Rheumat		heumatio	c Fever			
Y / N Bone Density Meds Y / N High blood p Y / N Cancer Y / N HIV, Aids			y Y/N Shingles B or C (circle one) Y/N Sinus Problems y/N Stomach ulcers, problems Y/N Stroke			equent headaches			
Y / N Chemotherapy, Radiation Y / N Joint replace Y / N Congenital Heart Defect Y / N Kidney Prob				nent Y / N Thyroid Problems			-		
Y/N	Diabetes	Y/N	Leukemia		Y/N To	uberculo	sis		
	Emphysema Fainting, Seizures, Epilep		Liver Proble Mitral Valve	ems Prolapse	Y/N V	enereal L	JISEASE		
	ything else you can t								
Today's blo	ood pressure	P	ulse						

	ease help us better understand your dental health needs and goals by answering the following questions neck the best answer):								
1.	. I am very satisfied satisfied dissatisfied with the appearance of my teeth.								
2.	I have a ☐ low ☐ moderate ☐ high fear of going to the dentist.								
3.	I think my present state of dental health is $\square$ excellent $\square$ good $\square$ fair $\square$ poor.								
4.	I would say that my main concerns with my dental health are:								
5.	I am interested in a smile evaluation and personalized treatment plan to enhance my smile.   Yes  No								
	DENTAL HISTORY								
Na	me of your previous dentist Date of last exam								
Wł	ny have you come to the dentist today?								
Do	you experience any stress or anxiety when you visit the dentist?								
W	nen were your teeth last cleaned?								
W	nen was your last full set of x-rays?								
What are your major complaints concerning your mouth?									
Do	your gums bleed while brushing or flossing?								
На	ve you ever been told you have gum disease?								
Do you have loose teeth?									
Are any of your teeth sensitive to hot or cold liquids, to sweets, to biting?									
Do you feel pain in any of your teeth?									
Do you have any unhealed sores or ulcers in your mouth?									
Have you had any head, neck, or jaw injuries?									
Are you aware of any clinching or grinding of your teeth?									
Have you experienced any of the following possible TMJ problems?									
C	Clicking, popping in your jaw? Yes No Difficulty in opening or closing? Yes No								
P	ain, soreness in jaw, temples? Yes No Difficulty in chewing? Yes No								
На	ve you had any orthodontic treatment?								
Do you wear dentures or partials?									
If you could change one thing about your smile, what would it be?									
If there were a simple, effective way to whiten your teeth, would you be interested?									
What have you liked most about any other dental office you have visited before?									
What have you liked the least?									