Don't Wait Until It Hurts. Let Us Help.

DENTAL INFORMATION

1. Are your teeth sensitive to hot or cold? Yes__ No__ Pressure? Yes__ No__ Sweets? Yes__ No__
2. Do you grind or clench your teeth? Yes__ No__
3. Do you have any fear of dental work? Yes__ No__
4. Date of last dental visit _______________ What was done at that time?____________________________
5. Former Dentist's Name ______________________ Phone Number________________________________
6. How would you describe your current dental problem? ____
7. How do you feel about the appearance of your teeth? ____

AMERICAN DENTAL ASSOCIATION WARNING SIGNS OF PERIODONTAL DISEASE

Periodontal disease is painless. It affects 75% of the population; often its victims are unaware.

8. Do your gums bleed when you brush your teeth? Yes__ No__
9. Are your gums red, swollen, or tender? Yes__ No__
10. Have your gums pulled away (receded) from your teeth? Yes__ No__
11. Do you have pus between teeth and gums when gums are pressed? Yes__ No__
12. Are your permanent teeth loose or separating? Yes__ No__
13. Have you noticed a change in the way your teeth fit when biting? Yes__ No__
14. Have you noticed any change in the fit of partial dentures? Yes__ No__
15. Do you have persistent bad breath? Yes__ No__

DO YOU EXPERIENCE ANY OF THE FOLLOWING:

Snoring	Yes__ No__	Jaw Clicking	Yes__ No__
Frequent Heavy Snoring	Yes__ No__	Head Pain	Yes__ No__
I have been told that I "stop breathing" when sleeping	Yes__ No__	Facial Pain	Yes__ No__
Daytime drowsiness	Yes__ No__	Neck Pain	Yes__ No__
Morning headaches	Yes__ No__	Limited mouth opening	Yes__ No__
Have other family members experienced one or more of the sleep symptoms listed above?	Yes__ No__	Other:	

Patient Information for Aesthetic Dentistry

Patient Name____Date:____________

Social Security Number:_______________________BirthDate__________________Family Status:_________

Phone:__Cell or Home____________________________Work __________________________________
Email: ____
Address:____City____________________________

State________________________________Zip Code_____________________

Health Information:_
Date of last dental visit:___________Reason for this visit:__________________________________
Have you ever had any of the following: Please check those that apply:

__AIDS	__Excessive Bleeding	__Liver Disease	__Stroke
__Allergies	__Fainting	__Mental Disorders	__Tuberculosis
__Anemia	__Glaucoma	__Nervous Disorders	__Tumors
__Arthritis	__Growths	__Pacemaker	__Ulcers
__Artificial Joints	__Hay Fever	__Pregnancy ________Due Date	__Venereal Disease
__Asthma	__Head Injuries	__Radiation Treatment	__Codeine Allergy
__Heart Disease	__Blood Disease	__Heart Murmur	__Respiratory Problems
__Cancer	__Hepatitis	__Rheumatic Fever	__Other
__Diabetes	__High Blood Pressure	__Rheumatism	
__Dizziness	__Jaundice	__Sinus Problems	
__Epilepsy	__Kidney Disease	__Stomach Problems	

Have you ever had complications following dental treatment: _____Yes ___NO
If yes, please explain____

Have you been admitted to a hospital or needed emergency treatment during the past two years?
___YES ___NO If yes, please explain:____

Are you now under the care of physician? ___YES ___NO
If yes, please explain:____

Name of Physician:____Phone:________________

Do you have any health problems that need further clarification? ___YES ___NO
If yes, please explain:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____Date:____________________
Signature of Patient, Parent or Guardian

Referral Information:

Whom may we thank for referring you to our practice? __Another Patient, Friend __Relative
__Dental Office __Yellow Pages __Newspaper __Work