

## Getting to Know You

How long has this been going on and what other events apply to today's visit?  Why have you decided to deal with this now?  Have you consulted with any other dentist about this? YES NO if Yes, what was discussed or dor  When was your last dental check up?  Who is your regular or previous dentist?  Have you noticed or has any dentist or hygienist ever said that you (please circle all that apply)  Have gum disease (gingivitis) YES NO Lip or cheek bleeding YES NO  Grind your teeth YES NO Loose or broken teeth or fillings YES NO  Clicking or popping jaw YES NO Food collection between teeth YES NO  Jaw pain or tiredness YES NO Sores, blisters or growths YES NO  Sensitivity to cold heat sweets when biting or chewi	Name			date _							
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Would you like to know your options to improve your smile look younger keep your tee	Sensitivity to	cold		heat sweets wh	nen biting or c	chewing					
miproto jour onino i jour gour de la	Would you like to know you	ır options	s to	improve your smile look younger	keep you	ır teeth					
What are your priorities and what would you like to see done now?	What are your priorities and	d what w	ould yo	ou like to see done now?							

## Personal Information & Health History

Name birth date Social Security No										
Mailing address City State Zip										
work		home co	ell		fax					
pageremail Marital Statussinglemarrieddivorcedwidowed										
How	or wh	o referred you to our office?								
Occu	patio	n Employer & address								
Spouse's occupation Employer & address										
Account responsibility (if someone other than yourself)										
Nam	e	birth date		Socia	al Security No					
Maili	ng ad	dress		dayti	me phone					
insur The r your	ance most i insura	CE: If you have dental insurance, we will provide you w company form for proper filing. You will receive a reimlimportant thing for you to know is the amount of your "ance carrier.  History (please circle "yes" or "no", if you have or ha	bursement direc 'calendar year m	tly for aximu	whatever you are entitled to. um" which you can find by calling					
		Are you in good health?	-		TB, asthma or lung disease					
YES		Has your health changed in the last year		NO	Diabetes					
YES		Chest pain, shortness of breath	YES	NO	Tumors, cancer					
YES	NO		YES	NO	Radiation treatment					
YES	NO	Headaches, ringing in ears	YES	NO	Psychiatric care					
YES	NO	Joint pain or stiffness, arthritis	YES	NO	Kidney or bladder disease					
YES	NO	Fainting or seizures	YES	NO	VD, herpes					
YES	NO	Heart disease, murmurs, rheumatic fever, prosthetic he	eart valve YES	NO	HIV positive, AIDS, ARC					
YES	NO	Pacemaker	YES	NO	Pregnant month					
YES	NO	High Blood pressure	YES	NO	Birth control pills					
YES	NO	Hepatitis or liver disease	YES	NO	Recreational drugs smoking/alcohol					
List a	any ar	nd all ALLERGIES								
List a	any ar	nd all DRUGS/MEDICATIONS you are taking								
List a	any ar	nd all SURGERIES								
Are y	ou be	eing treated by a Doctor now? YES NO Who?								
The above information is true and correct to the best of my knowledge.										
PATI	ENT S	SIGNATURE			DATE					