DENTAL HISTORY

	Yes	No
1. Are your teeth sensitive to:		
Heat?	❑	❑
Cold?	❑	❑
Sweets?	❑	❑
Biting Pressure?	❑	❑
2. Does food constantly get stuck between certain teeth in your mouth?	❑	❑
3. Do you get frustrated when you always have something to be treated or repaired when you visit a dentist?	❑	❑
4. Are you dissatisfied with the way your teeth look?	❑	❑
5. Would you like your teeth to be whiter?	❑	❑
6. Would you like your teeth to be straighter?	❑	❑
7. Do you have spaces between your teeth that you would like closed? If so, where? ________________	❑	❑
8. Do you like the shape of your teeth?	❑	❑
9. Do you have any silver fillings that you don't like and want replaced?	❑	❑
10. Do you have any missing teeth that you would like to replace?	❑	❑
11. Do your gums bleed when brushing? If so, explain? ________________	❑	❑
12. Have you been instructed regarding proper home care?	❑	❑
13. Do you have an unpleasant odor in your mouth?	❑	❑
14. Do you smoke or use any tobacco products?	❑	❑
15. Do you frequently snack between meals on sweets or chew gum?	❑	❑
16. How often do you brush your teeth? Select one: 0, 1, 2 or 3 times a day?		
17. How often do you floss your teeth? Select one: 0, 1, 2 or 3 times a day?		
18. Do you want to control dental disease and retain your teeth?	❑	❑
19. Has the fear of discomfort kept you from regular dental visits?	❑	❑
20. Are you deeply concerned about the finances required to return your mouth to excellent dental health?	❑	❑

21. On a scale of 1 to 10, how would you rate your teeth and oral health? _______

22. If you could change anything about your smile, what would that be? Please explain: ________________

____

MEDICAL HISTORY

	Yes	No
Do you have any general health problems? If so, please specify ________________	❑	❑
Are you currently under a physician's care? Reason ________________	❑	❑

Name and Address of Physician ________________

____

____

	Yes	No
Are you currently taking any drugs or medication? If so, what? ________________	❑	❑

To the best of your knowledge, are you or have you ever been afflicted with:

	Yes	No
Heart Ailment	❑	❑
Diabetes	❑	❑
Rheumatic Fever	❑	❑
Epilepsy	❑	❑
Respiratory Disease	❑	❑
Hepatitis	❑	❑
Type _______		
Prolonged Bleeding	❑	❑
Healing Complication	❑	❑
Allergy to any Drugs	❑	❑
HIV Positive	❑	❑
Venereal Disease	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Acute Narrow Angle Glaucoma	❑	❑

Height ________ Weight ________

Signature: ________________________________

Blood Pressure ________________ Pulse ___________

Respiration ____________ Date ___________ Initial _________