

REGISTRATION AND HEALTH HISTORY

Name _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Spouse Name _____

Social Security number _____

Birthdate _____

Residence address _____

City _____

State _____

Zip _____

Home phone _____

Employed by _____

City _____

State _____

Zip _____

Business phone _____

Present position _____

How long held _____

Your driver license no. _____

State _____

Spouse employed by _____

City _____

State _____

Zip _____

Phone _____

Present position _____

How long held _____

Spouse driver license no. _____

State _____

Spouse's Social Security number _____

Spouse birthdate _____

Referred by _____

Address _____

Who will pay for this account? _____

Credit card name _____

No. _____

Expiration date _____

Name of your dental insurance company _____

Union local _____

Group no. _____

Policy no. _____

Name of your spouse's dental insurance company _____

Union local _____

Group no. _____

Policy no. _____

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

YOUR DENTAL HISTORY

Are you having any discomfort at this time _____ How long since you have been to a dentist _____ What was done then _____

Did you have X-Rays _____ How often did you visit a dentist before then _____ Have you lost any teeth _____ Why _____

Any complications with extractions _____

Have they ever been replaced by: (1) A Fixed Bridge _____

(2) Removable Partial _____ (3) Denture _____

How many of (1) (2) (3) _____

Are your teeth sensitive to heat _____ to cold _____ to sweets _____ to sour _____ Have you had your teeth straightened _____

When _____ How often do you brush your teeth _____ When _____

How _____

How long do you use a toothbrush before replacing it _____

Do you use dental floss _____ How often _____

Between-the-teeth stimulator _____ Water jet _____

Do you have bleeding gums _____ When _____

Do you eat between meals _____ Do you brush teeth after

snacks _____ Does food wedge between your teeth _____

Where _____ Do you grind or clench

your teeth _____ When _____

Have you ever had gum treatments _____ When _____

Do you feel you have bad breath at times _____

Unpleasant taste in mouth _____ Any pain in or around

your ears _____ Do you hear popping, clicking or snapping

noises when you chew _____ Do you have any nasal

obstruction _____ Are you aware of any swelling or lump

in your mouth _____

