

Have you experienced any discomfort from gums lately? _____
Describe _____ Do they bleed easily? _____
Have you noticed any discomfort or any unusual changes in the soft tissues of the mouth? (tongue, cheek, throat, lips, etc.)

How often do you brush? _____ Do you use dental floss? (Frequency) _____
Are you frequently troubled with bad breath? _____

Do you have any unusual eating habits? _____
Do you snack between meals frequently? _____

Does the appearance of your teeth, in any way make you self-conscious? _____
Explain: _____

Would you like to retain your natural teeth as long as possible? _____
If not, explain: _____

Do any of the following apply? (PLEASE CHECK THOSE THAT APPLY)
Popping _____ Snapping noises when you chew _____ Pain when opening wide _____ Discolored teeth _____
Clicking _____ Missing teeth other than wisdom teeth _____ Clenching your teeth _____ Frequent headaches _____
Loose teeth _____ Have missing teeth been replaced _____ Shifted or tipped teeth _____ Grinding teeth in sleep _____
Loose fillings _____ Fillings that have to be replaced often _____ Chipped or discolored fillings _____ Nerves removed _____

Health Information

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Growths	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Penicillin Allergy	Other: _____				

Have you been admitted to a hospital or needed emergency care during the past 2 years? Yes No

If yes, please explain: _____

Are you under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____

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.

Signature of patient, parent or guardian

Date

Referral Information

Whom may we thank for referring you to our practice? _____

