CONFIDENTIAL

Last Name	First ❑ Male ❑ Female	Initial	Res. Phone	Date of Birth	Whom may we thank for referring you to our office?
					Date

Address	City	State, Zip	Bus. Phone	If Child, Parents Name

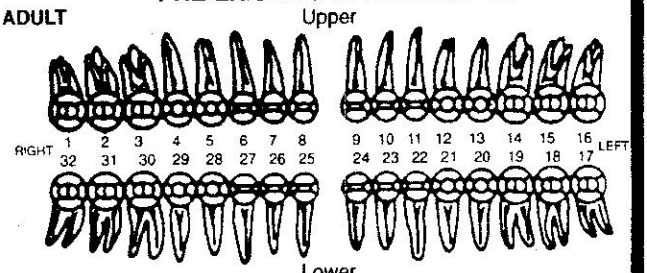
Name of Employer	Your SS #	Married	Single	Bank	Branch	Name of Spouse

Plant	Spouse Employer

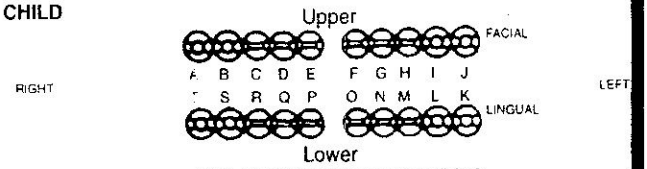
DO NOT WRITE BELOW RED LINE

PRE-EXISTING RESTORATIONS

ADULT

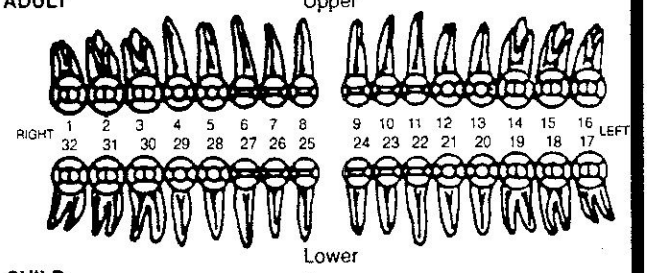


CHILD

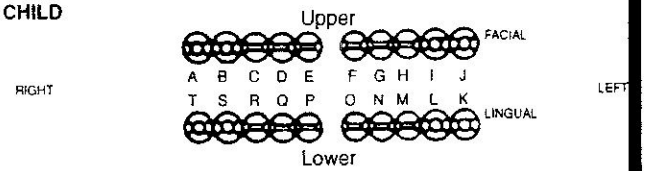


NEEDED RESTORATIONS

ADULT



CHILD



REMARKS

Oral Hygiene: Good ❑ Fair ❑ Poor ❑
Calculus: Heavy ❑ Medium ❑ Light ❑

Abnormalities	Tooth #	Abnormalities	Tooth #
Abrasion	___	Mottling	___
Attrition	___	Intrinsic Stains	___
Erosion	___	Fractured Tooth	___
Hypocalcification	___		

ORTHODONTICS: ❑ YES ❑ NO

MALOCCLUSION:
❑ CLASS I ❑ CLASS II ❑ CLASS III

DENTITION:
❑ ADULT ❑ MIXED ❑ PRIMARY

CROWDING:
❑ UR ❑ UL ❑ LR ❑ LL

Blood Pressure: _____

Nearest Relative (other than spouse): _____
Address and Phone: _____
_____

DENTAL HISTORY

Are you having any discomfort? _____
❑ Lower Right, ❑ Lower Left, ❑ Upper Right, ❑ Upper Left
Date of Last Dental Exam: _____ Cleaning: _____
Were Complete X-Rays Taken? Yes _____ No _____
Reason for this visit: _____
Would you like to keep your natural teeth? _____
Do your gums bleed? _____
Are you aware of grinding or clenching your teeth? _____
Has the fear of discomfort kept you from the dentist? _____
Are you self conscious about the appearance of your teeth? ___
Are you satisfied with past dentistry? _____
Explain: _____
Would you prefer a local anesthetic? _____
Nitrous Oxide gas? _____

I hereby grant my permission to administer any treatment which may be necessary in the diagnosis and treatment of

_____ .

I also understand there is no guarantee of a desirable result in any dental treatment.

Signed: _____
Patient/Parent Guardian

DRAW ABNORMALITIES

Soft & Hard Tissues	Normal
Lips	❑
Buccal Mucosas	❑
Alveolar Processes	❑
Gingivae	❑
Habits	❑
TMJ	❑
Palate	❑
Tongue	❑
Floor of the Mouth	❑
Salivary Glands	❑
Oropharynx	❑