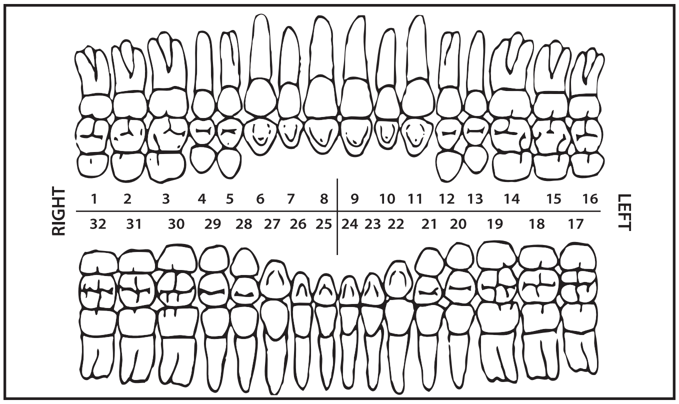
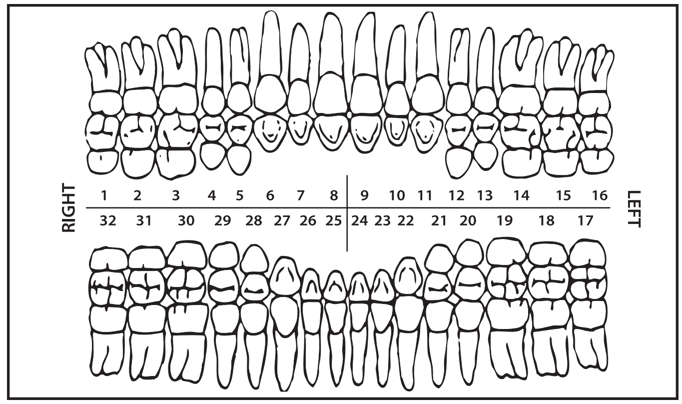
NAME ____________________





DENTAL TREATMENT ____________________

MEDICAL CONSULTATION ____________________

Date	Tooth	Surface	Service Necessary	Fees		Date	Tooth	Surface	Service Necessary	Fees

1. Purpose of initial visit _____

_____

2. How long since your last dental visit? _____

3. What was done at that time? _____

4. Previous dentist's name: _____

Address: _____ Phone: _____

5. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

6. Have you made regular visits? Yes No

How often? _____

7. Were dentral x-rays taken? Yes No

8. Have you lost any teeth or have any teeth been removed? Yes No

Why? _____

9. Have they been replaced? Yes No

a. Fixed bridge _____ Age of Restoration _____

b. Removable bridge _____ Age of Restoration _____

c. Denture _____ Age of Restoration _____

10. Are you unhappy with the replaceement? Yes No

If yes, explain: _____

_____

11. Would you like to know about permanent replacements? Yes No

12. Have you ever had any problems or complications with previous dental treatments? Yes No

If yes, explain _____

_____

13. Do you clench or grind your teeth? Yes No

14. Does your jaw click or pop? Yes No

15. Have you experienced any pain or soreness in the muscles of your face or around your ear? Yes No

16. Do you have frequent headaches, neck aches, or shoulder aches? Yes No

17. Does food get caught in your teeth? Yes No

18. Are any of your teeth sensitive to: ❑ Hot? ❑ Cold? ❑ Sweets? ❑ Pressure?

19. Do your gums bleed or hurt? Yes No

When? _____

20. How often do you brush your teeth? _____

21. Do you use dental floss? _____

How often? _____

22. Are any of your teeth loose, tipped, shifted or chipped? Yes No

23. Are you unhappy with the appearance of your teeth? Yes No

24. How do you feel about your teeth in general? _____

_____

25. Do you feel your breath is offensive at times? Yes No

26. Have you ever had gum treatment or surgery? Yes No

When? _____

27. Have you ever had orthodontic work? Yes No

28. Have you had any unpleasant dental experiences or is there anything else we should know to make your visits more comfortable? _____

_____

29. Do you have any questions or concerns? _____

_____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____