PATIENT'S DENTAL HISTORY

Reason for today's visit					
Former Dentist	City/State				
	Date of last dental X-rays				
MARK YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:					
Bad Breath	Yes[] No[]				
Bleeding Gums					
	Yes[] No[]				
Chew on ONE Side of Mouth					
Clicking or Popping of Jaw	Yes[] No[]				
Dry Mouth	Yes[] No[]				
Fingernail Biting					
Food Collection between Teeth (more tha	an normal) Yes[] No[]				
Grinding Teeth	Yes[] No[]				
Gums Swollen & Tender_	Yes[] No[]				
Jaw Pain or Tiredness	Yes[] No[]				
Lin or Chook Diting	Yes[] No[]				
Loose Teeth or Broken Fillings	Yes[] No[]				
Mouth Breathing	Yes[] No[]				
Mouth Pain, Brushing	Yesi Noi				
Braces (Orthodontic Treatment)	Yes[] No[]				
Dain around Fora	Yes[] No[]				
Gum Disease(Periodontal Disease)	Yes[] No[]				
Sensitivity to Hot /Cold	Yes[] No[]				
Sensitivity to Sweets	Yes[] No[]				
Sensitivity when Biting	Yes[] No[]				
Sores in your Mouth	Yes[] No[]				
Do you use any form of Tobacco	Yes[] No[]				
Are you having any PAIN at this TIME _	Yes[] No[]				
Are you NERVOUS about having DENT	`AL Treatment Yes[] No[]				
Have you ever had a BAD EXPERIENCE	E in a Dental Office Yes[] No[]				
How often do you FLOSS?	& BRUSH?				
Harra view I OCT once TEETH9					
Were REPLACEMENTS discussed for M	Missing Teeth?				
Do you consume Sugar Products between	n Meals?				
Do you Feel you have Good Teeth?					
Are you Happy with the Appearance of y	our teeth?				

Today's Date	<u></u>
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DENTAL REGISTRATION & HISTORY

PATIENT'S NAME		1	BIRTHDATE	
[]Single	[]Married	[]Divorced	[]Child	
NAME OF: []PARENT []S	POUSE IIGI	HARDIAN		
Patient's Address Info				
Street Address	oi illation	CITY	CT	71D
Street Address Home #_ E-mail	Worls#	C11 1	51 51	ZIP
E mail	WOIK#	Dag	t way to contact	. VOII
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{ }PATIENT'S { }PARENT'S ADDRESS	EMPLOYER	DDECENIA	DOCITION	1 KS Employed
OSPOUSE OCHARDIAN EN	MDLOVED	PRESENT	POSITION	YRS EmployedYRS Employed
{ }SPOUSE { }GUARDIAN EN ADDRESS Patient's nearest Relati	WIPLOYER	DDECENI	DOCITION	1 KS Employed
ADDRESS	•	PRESENT	PUSITION	
Patient's nearest Kelati	ive		Pnone_	
ADDRESS			D1	<u> </u>
Spouse nearest Relativ	re		Phone	_
ADDRESS				<u> </u>
PATIENT'S SSN#	27.127.0027//			
SPOUSE/PARENT/GUARI	DIAN SSN#_			
T f D		CIT	LICHTON	
	DEN	ASH ITAL INSURANG	CE .	[]CREDIT CARD
	DEN	ITAL INSURANC	CE .	
INSURANCE COADDRESS	DEN	ITAL INSURANG	CE GI ST	ROUP#ZIP
INSURANCE COADDRESS	DEN	CITYSUBSCRI	CEGI _ST BER NAME	ROUP#ZIP
INSURANCE COADDRESS TELEPHONE #BIRTHDATE	DEN SSN#	CITYSUBSCRI	GEGEST BER NAME	ROUP #ZIPRelation to Pt
INSURANCE COADDRESS TELEPHONE #BIRTHDATE Is Patient covered	SSN#d by second:	CITYSUBSCRI	GE ST BER NAME rance? []YES	ROUP #
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INSURANCE COADDRESS TELEPHONE # BIRTHDATE Is Patient covered 2nd INSURANCE CO ADDRESS	SSN#_d by second:	CITYSUBSCRIPARY dental insu	GE ST ST BER NAME rance? []YES G	ROUP #ZIP
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