Please check any of the following problems that apply to you.	
- Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐
- Headaches, earaches, neck pain	☐
- Jaw joint pain	☐
- Teeth or fillings breaking	☐
- Grinding or clenching teeth	☐
- Bleeding, swollen or irritated gums	☐
- Loose, tipped or shifting teeth	☐
- Bad breath	☐
Do you have or have you had any of the following?	☐
-Dentures	☐
-Partial dentures	☐
-Braces	☐
-Periodontal (gum) treatments	☐

Please share the following dates:	
-Your last cleaning	___/___
-Your last oral cancer screening	___/___
-Your last complete X-Rays	___/___

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

If you could whiten your teeth for a cost anyone could afford, would you do it?	☐
Do you smoke or use chewing tobacco? How much? _____ For how long? _____	☐
If I could change my smile, I would:	☐
-Make them whiter	☐
-Make them straighter	☐
-Close spaces	☐
-Replace black metal fillings with tooth colored restorations	☐
-Repair chipped teeth	☐
-Replace missing teeth	☐
-Replace old crowns that don't match	☐
-Have a smile makeover	☐

On a scale of 1 – 10, with 10 being the highest rating:

- How important is your dental health to you?
  1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?
  1 2 3 4 5 6 7 8 9 10
- Where do you want your dental health to be?
  1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today? _____

What is the most important thing to you about your future smile and dental health? _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Venereal Disease	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes