

(Please Print)

Today's date: _____			
PATIENT INFORMATION			
Name: _____		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
Phone Number: _____		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Marital status (circle one) Single / Mar / Div / Sep / Wid			
Home address: _____		City: _____	State: _____ ZIP Code: _____
Occupation: _____	Employer: _____		Employer phone no.: _____
Employer address: _____		City: _____	State: _____ ZIP Code: _____
Employer phone no.: _____			
Spouse's Name: _____		Spouse's Occupation: _____	
Employer address: _____		City: _____	State: _____ ZIP Code: _____
Employer phone no.: _____			
Whom may we thank for referring you? _____			

FOR INSURANCE PURPOSES:	
Do you have DENTAL Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Carrier: _____
Social Security Number: _____	Group Number: _____

DENTAL HISTORY	
Are your teeth sensitive to: Heat? <input type="checkbox"/> Yes <input type="checkbox"/> No Cold? <input type="checkbox"/> Yes <input type="checkbox"/> No Sweets? <input type="checkbox"/> Yes <input type="checkbox"/> No Biting Pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does food constantly get stuck between certain teeth in your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you dissatisfied with your teeth in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any filling that show in your front teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No Do any of your fillings show when you smile? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had any teeth removed? <input type="checkbox"/> Yes <input type="checkbox"/> No How long have these teeth been missing? _____	
Do your gums bleed when brushing? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever avoid any part of the mouth when brushing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been instructed regarding proper home care? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have an unpleasant taste or odor in your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently snack between meals on sweets or chew gum? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How often do you brush your teeth? _____ How often do you use floss? _____	
Do you want to learn to control dental disease and retain your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the fear of discomfort kept you from regular dental visits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you deeply concerned about the finances required to return your mouth to excellent dental health? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When was your last dental appointment? _____ What did you have done? _____	
How long since your last <i>thorough</i> examination with <i>full mouth x-rays</i> ? _____	
What prompted you to seek dental care at this time? _____	
Why did you leave your last dentist? _____	

*Maribel M.
Tann, D.D.S.*

General Dentistry and Orthodontics
For Adults and Children

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MEDICAL HISTORY

Do you have any general health problems? Yes No If so, please specify _____

Are you currently under a physician's care? Yes No Reason _____

Name and Address of Physician _____

Are you currently taking any drugs or medication? Yes No If so, what? _____

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.:

To the best of your knowledge, are you or have you ever been afflicted with:

Hearth Ailment Yes No Diabetes Yes No Artificial Hip or Prosthesis Yes No Rheumatic Fever Yes No

Epilepsy Yes No High Blood Pressure Yes No Respiratory Disease Yes No Hepatitis Yes No

Prolonged Bleeding Yes No Healing Complication Yes No Allergy to any Drugs Yes No

Would you like us to take your blood pressure? Yes No

Person Financially Responsible for this account _____

SIGNATURE _____