

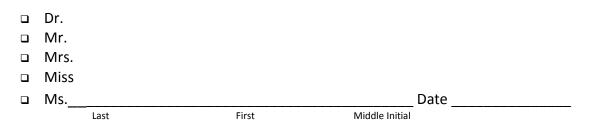
Date : _____

REGISTRATION AND HEALTH HISTORY

Name:	Social Security #:				
Name we should call you:	Date of Birth:				
Home Phone #:Ce	II #: E-mail Address:				
Address:	City/State/Zip				
Employed By:	Driver's Lic # and State Issued				
Position:	Work Phone#				
Marital Status:	Spouse's Name:				
Spouse's SS#:	Spouse's Date of Birth:				
Spouse Employed By:					
Position:	Work Phone#:				
Nearest Relative (In case of emergen	cy):				
Phone #:	City & State:				
Who may we thank for referring you	to our practice?				
Who will pay your account?					
Purpose of this visit:					
Employer that Carries Insurance: Address of Primary Dental Insurance	ompany: Co:DOB:				
	If Applicable) Group #:				
	ysician:				

Please Complete the Separate MEDICAL HISTORY FORM

Initial Visit Interview



Your answers to this dental history questionnaire will help us understand your specific dental problems, so that we may effectively treat you with consideration for your individual needs.

Previous Dentist				Specialty Date of Last Visit		
Period of Treatment						
Address _						
	Number	Street	City	State	Zip Code	(area code) Phone
What is y	our imme	diate dental	concern?			

Please check YES or NO (or circle one).

- 1) I think I am:
 - □ In Excellent oral health.
 - □ In Good oral health.
 - □ In Poor oral health.
- 2) I desire:
 - □ Excellent oral health.
 - □ Average or Good oral health.
 - □ Crisis Care only.
- 3) Are you presently in pain? YES or NO
 - I Teeth
 - Gums
 - 🗆 Jaw
 - □ Face
 - Other _____

4) Is any part of your mouth sensitive to the following? YES or NO

- 🗆 Hot
- □ Cold
- Sweet
- □ Sour
- Pressure
- Other _____

- 5) Do you have a burning sensation in your mouth? YES or NO
- 6) Are you troubled with dryness in your mouth? YES or NO
- 7) Do you have any pain or soreness around your ears, cheeks, or other parts of your face? **YES** or **NO**
- 8) Do you have chronic headaches? YES or NO
- 9) Have you ever had periodontal treatment or gum surgery? **YES** or **NO** If Yes, when? _____ By Whom? _____
- 10) Have you ever been informed of any gum problems? **YES** or **NO** If Yes, when? _____ By Whom? _____
- 11) Do your gums bleed when you brush your teeth? YES or NO
- 12) Does food catch between your teeth? YES or NO
- 13) Do you drink sodas/pop? YES or NO
- 14) Are you aware of a bad taste or odor in your mouth? YES or NO
- 15) Please indicate which items you use daily.
 - Hard-bristle toothbrush
 - Soft-bristle toothbrush
 - Electric toothbrush
 - Proxi-brush
 - Rubber Tip
 - Dental Floss
 - Water Spray
 - Stimudents or toothpicks
 - Other _____
- 16) Are you aware of any growths or swelling in your mouth? **YES** or **NO** If Yes, Where are they located and how long have they existed?
- 17) Do you have frequent cold sores, canker sores, or fever blisters on your gums, cheeks or lips? **YES** or **NO** If Yes, how often?
- 18) Are you aware of your jaw clicking, popping, or making grating-like noises? YES or NO If Yes, when?
- 19) Do your jaw muscles feel tired, stiff or painful? YES or NO
- 20) Do you chew gum? YES or NO
- 21) Are you aware of clenching your teeth during the day? YES or NO If Yes, how often?
- 22) Have you ever been told that you grind your teeth during your sleep? **YES** or **NO** If Yes, how often?
- 23) Do you wear a removable denture or appliance? **YES** or **NO** If Yes, when do you wear it?
- 24) Are you frustrated by needing constant dental repair because of active dental disease? **YES** or **NO**
- 25) Are you anxious about dental treatment? YES or NO
- 26) Do you have any disease or known condition which has not been addressed in the

above. That you feel is important for us to know? If Yes, please explain: ______

- 27) My mouth is:
 - □ Very Comfortable.
 - Moderately Comfortable.
 - □ Uncomfortable.
- 28) I:
 - **D** Think the appearance of my mouth is excellent.
 - **u** Think the appearance of my mouth is adequate.
 - Wish I could change the appearance of my mouth.
 If so, what would you change?

29) I:

- Want to save my teeth at all costs.
- Prefer to keep my teeth if cost and time are reasonable.
- Am not very interested in setting personal goals to achieve optimum oral health.

30) I:

- **u** Have followed the recommendations for optimum dental health given by my dentist.
- □ Have not done what dentists recommended I do with my mouth.
- □ Usually only go to the dentist for emergencies.
- 31) What are some questions about dentistry and your oral health that you have never had

adequately answered? _____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medications change, I will inform Dr. Hatcher or his staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to dental insurance claims.) I understand that I am responsible for all costs of dental treatment and that before credit is extended, a credit report will be obtained.