raue	nt information
Patient's Name	Today's Date
Home Address	
CityZip	Res. Tel.#
Social Security # Date of Birth	// Age Marital Status S/M/D/W
Your Occupation Employer_	Bus.Tel#
Spouse's Name Date	of birth/Social Security #
Your spouse's OccupationEm	ployerBus.Tel#
Person to contact in an emergency	Relation
Res. Tel. # Bus. Tel. #	Address
Party responsible for account	Bus Tel. # Res Tel.#
Reason for this visit	
Whom may we thank for referring you?	
	LTH HISTORY
For your safety and to assist us in accurately diagnosing and treating	ng you, please carefully review this form completely and fill out all areas whic
pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL	
Dental History:	
	City How long
	aning Date of last full mouth x-ray
1. Why did you leave your last dentist?	
	office you have been to?
	fice that you have been to?
4. Are you having any discomfort at this time?Ye	
5. Have you ever had any serious trouble associated with	
6. Does dental treatment make you nervous?Ye	
7. Have you ever been treated for periodontal disease (g	um disease, pyorrhea, trench mouth)?YesN
Check any of the following you have had or currently	have:
Mouth discomfort	Mouth Odor or Bad Taste
Periodontal Treatment	Cold Sores or Fever Blisters
Trenchmouth or Pyorrhea	Other Oral Lesions
Gum Abscesses	Bad Dental Experience
Gums Bleed when Brushing	Loose or Shifting Teeth
Trouble Chewing/Speaking	Bruise Easily
Grind or Clench your teeth	Sensitive Teeth (Hot, Cold, Sweets)
Pain, Clicking, Popping in Jaw Joints	Fear of Dental Treatment
Orthodontic Treatment	Awake with Sore Jaws
Immediate Relatives that have lost all of	Complications with or following previous
their Natural Teeth	Dental or Oral Surgical treatment
If you could change one thing about your smile, what wo	ould that be?
Do you want to keep your teeth? Yes, no matter how Yes, if it's not too	And the state of t