**We would like to get to know you better!**

Date:___________

Personal Notes:_______________________ Favorite Restaurant:___________________

**Name:**_____________________________________________ Male ( ) Female ( )

Address:_____________________________________________ Zip Code:__________

Home Phone:______________ Cell Phone:_______________ Work:_______________

Would you like to receive email ( ) or text message ( ) reminders and discounts?

Email Address:________________________________

Whom can we thank for referring you to our office?______________________________

Date of Birth:_________________ Social Security Number________________________

Occupation:______________________________________________________________

Emergency Contact: ____________________________ #_________________________

***General Health Questions:***

Are your teeth sensitive to: Heat, Cold, Biting Pressure or Sweets?__________________

Does food catch between your teeth?______________ Any Odors?_________________

Do your gums bleed when you brush?_________ Any Swelling?___________________

Any jaw problems: Clicking, Pain, Difficulty opening, closing or chewing?__________________________________

Have you ever had a reaction to the local anesthetic?___________________

Do you smoke?___________

Have you had your wisdom teeth removed?___________________ When?___________

When was your last thorough dental examination?__________________ Pano?________

Are you under a physicians care or do you have any general health conditions?______________________________________________________________

Current Medications:_______________________________________________________

Have you had surgery?______________________________________________________

To the best of your knowledge have you been afflicted with : (please circle)

| | |
|---|---|
| Heart Ailment | Epilepsy |
| Diabetes | High Blood Pressure |
| Rheumatic Fever | Respiratory Disease |
| Hepatitis | HIV Positive |
| Prolonged Bleeding | Healing Complications |

Do you have any drug or latex allergies?_________________________________________

Why did you leave your last dentist?____________________________________________

What do you see for your teeth in 5- 10 years?_________________________________

Signature:___________________________________________Date:________________