



WHAT DON'T YOU LIKE ABOUT YOUR TEETH?

- | | |
|---|--|
| <input type="checkbox"/> CROWDING/CROOKED TEETH | <input type="checkbox"/> JAW JOINT PAIN |
| <input type="checkbox"/> SPACES | <input type="checkbox"/> MISSING TEETH |
| <input type="checkbox"/> TOOTH SHAPE | <input type="checkbox"/> DARK TEETH |
| <input type="checkbox"/> TOOTH SIZE | <input type="checkbox"/> SPEECH PROBLEMS |
| <input type="checkbox"/> GUMMY SMILE | <input type="checkbox"/> OVERBITE |
| <input type="checkbox"/> UNDERBITE | <input type="checkbox"/> FACIAL PROFILE |
| <input type="checkbox"/> TEETH ARE DIFFERENT COLORS | <input type="checkbox"/> UGLY OLD CROWNS |
| <input type="checkbox"/> OTHER _____ | |

I AM INTERESTED IN:

- | |
|--|
| <input type="checkbox"/> 6-MONTH BRACES |
| <input type="checkbox"/> TEETH WHITENING |
| <input type="checkbox"/> VENEERS |
| <input type="checkbox"/> OTHER _____ |

IS THERE ANYTHING YOU WOULD LIKE THE DENTIST TO KNOW?



PRELIMINARY HEALTH HISTORY FORM

NAME: _____ DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ BIRTHDATE: _____
WORK PHONE: _____ CELL PHONE: _____
OCCUPATION/EMPLOYMENT: _____
SOCIAL SECURITY NUMBER: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (circle one)
TV RADIO DIRECT MAIL FRIEND/FAMILY OTHER

WHAT IS YOUR EMAIL ADDRESS? _____

ARE YOU **ALLERGIC** TO ANY **MEDICATIONS**? _____

ARE YOU ALLERGIC TO **LATEX**? _____

DO YOU HAVE, OR HAVE YOU HAD HEART TROUBLE, HEART MURMUR, RHEUMATIC FEVER, VALVE DISEASE/REPLACEMENT, OR MITRAL VALVE PROLAPSE? (OR ANY OTHER CONDITION REQUIRING **PREMEDICATION** WITH ANTIBIOTICS)? _____

WHEN WAS THE APPROXIMATE DATE OF YOUR LAST DENTAL CLEANING?

NAME AND TOWN OF CURRENT DENTIST: _____

WE ARE HERE TO OFFER YOU THE LATEST AND GREATEST IN COSMETIC DENTISTRY. WE HOPE YOU ENJOY YOUR STAY!



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