HEALTH HISTORY

Date	Patient Name		Name you v	wish to be called	
Physical Address			Home	Phone	
City	Sta	te Zip Code	Work	Phone	
Mailing Address			Cell F	Phone Phone Zip Code Separated Divorced	
City	Star	te		Zip Code	
Best Time and Place to	Reach You Live and In 1	Person			
Sex: M F Age _	Birthdate	Single M	arried Widowed	Separated J Divorced	
Patient SS #	Occ	upation	Employe	er	
Employer Address			Employer Phone _		
Spouse Name		Spouse Phone		er	

IN CASE OF EMERG	ENCY PLEASE CONTA	CT (someone not living	with you)		
Name		*	Relationship to yo	u	
Address and Phone Nu	mber of Emergency Con	tact Person			
Whom may we thank for	or referring you?			ationship to patient	
Who is responsible for	this account?		Rela	ationship to patient	

Insurance Company		3		Group #	
Is patient covered by a	dditional insurance? [†] yes	no Subscriber's name			
Subscriber's Birthdate	Subsci	riber's SS#	Re	lationship to Patient	
Insurance company				Group #	
ASSIGNMENT AND R	RELEASE				
	ify that I (or my depende				
				that I am financially responsible for	
				rmation necessary to secure the payr	nent
of benefits. I authorize	e the use of this signature	on all insurance submis	sions.		
	0				
			2		
Responsible Party Sign			tionship	Date	ī
	ature	Rela	tionship		
	ature	Rela	tionship	Date	
	ature	Rela	tionship		
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Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath	ature ******* to indicate if you have ha	Rela ******** DENTAL HIST City/Sta Date of I ad any of the following:	tionship ********* FORY teast dental X-rays	**************************************	
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation	ature ********* to indicate if you have have have have have have have have	Rela ********* DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums	TORY teast dental X-rays	Blisters on lips or mouth † Yes † No	0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue	ature ********* to indicate if you have have have have have have have have	Rela ********** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth	TORY teast dental X-rays	Blisters on lips or mouth \(\tilde{Y} \) Yes \(\tilde{N} \) No cigar ette, pipe or cigar smoking	0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation	ature ********** to indicate if you have have fixes in No	Rela ********* DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one	TORY te ast dental X-rays yes i No yes i No	Blisters on lips or mouth \(\tilde{\tau} \) Yes \(\tilde{\tau} \) No cigarette, pipe or cigar smoking	0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue Clicking or popping Jaw	ature ********** to indicate if you have have fixes in No	Rela *********** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth	TORY te ast dental X-rays yes i No yes i No	Blisters on lips or mouth \(\tilde{\text{Yes}} \) No Cigarette, pipe or cigar smoking \(\tilde{\text{Yes}} \) No Fingernail biting \(\tilde{\text{Yes}} \) No	0 0 0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue Clicking or popping Jaw Do you or have you	ature ********** to indicate if you have have fixes in No	Rela ******** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth Food collection between teeth	TORY te ast dental X-rays yes i No yes i No	Blisters on lips or mouth \(\times \) No Cigarette, pipe or cigar smoking \(\times \) Yes \(\times \) No Chewing tobacco \(\times \) Yes \(\times \) No Grinding teeth \(\times \) Yes \(\times \) No Grinding teeth	0 0 0 0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue Clicking or popping Jaw	ature ********** to indicate if you have have fixes in No	Rela ******** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth Food collection between teeth Foreign objects	TORY te	Blisters on lips or mouth Î Yes Î No Cigarette, pipe or cigar smoking Î Yes Î No Fingernail biting Î Yes Î No Chewing tobacco Î Yes Î No Grinding teeth Î Yes Î No	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue Clicking or popping Jaw Do you or have you ever experienced pain/discomfort	ature ********** to indicate if you have have fixes in No	Rela ******** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth Food collection between teeth	TORY te	Blisters on lips or mouth \(\text{Yes} \) No Cigarette, pipe or cigar smoking \(\text{Yes} \) No Chewing tobacco \(\text{Yes} \) No Chewing tobacco \(\text{Yes} \) No Cigarette, pipe or cigar smoking \(\text{Yes} \) No Chewing tobacco \(\text{Yes} \) No Chewing tobacco \(\text{Yes} \) No Cinding teeth \(\text{Yes} \) No Cipor cheek biting \(\text{Yes} \) No Cipor cheek biting	0 0 0 0 0 0
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Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue Clicking or popping Jaw Do you or have you ever experienced pain/discomfort in your jaw joint Food collection tender	to indicate if you have have if Yes i No i Yes i No	Rela ********** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth Food collection between teeth Foreign objects Jaw pain or tiredness Mouth	TORY te ast dental X-rays i Yes i No	Blisters on lips or mouth Ves Not Cigarette, pipe or cigar smoking Ves Not Chewing tobacco Grinding teeth Lip or cheek biting Orthodontic treatment Gums swollen or Sensitivity when biting Yes Not Sensitivity when Sensit	0 0 0 0 0 0 0 0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue Clicking or popping Jaw Do you or have you ever experienced pain/discomfort in your jaw joint Food collection tender Periodontal	to indicate if you have have if Yes i No i Yes i No	Rela *********** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth Food collection between teeth Foreign objects Jaw pain or tiredness Mouth breathing Sensitivity to cold	TORY te ast dental X-rays i Yes i No	Blisters on lips or mouth Ves No Cigarette, pipe or cigar smoking Ves No Fingernail biting Ves No Grinding teeth Ves No Cigarette biting Ves No Chewing tobacco Ves No Corthodontic treatment Gums swollen or Sensitivity when biting Do you like your smile Type of bristles Hard	0 0 0 0 0 0 0 0
Reason for today's visit Former Dentist Date of last dental visit Please check Yes or No Bad breath Burning sensation on tongue Clicking or popping Jaw Do you or have you ever experienced pain/discomfort in your jaw joint Food collection tender Periodontal Loose teeth or	to indicate if you have have if Yes i No i Yes i No	Rela *********** DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth Food collection between teeth Foreign objects Jaw pain or tiredness Mouth breathing Sensitivity to cold treatment	TORY te ast dental X-rays i Yes i No	Blisters on lips or mouth Ves No Cigarette, pipe or cigar smoking Ves No Cigarette, pipe or cigar smoking Ves No Cigarette, pipe or Ves No Cigarette, pipe of bristles Archives No Cigarette, pipe of No	0 0 0 0 0 0 0 0
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Reason for today's visit Former Dentist	to indicate if you have have if Yes i No i Yes i No	Rela ********* DENTAL HIST City/Sta Date of I ad any of the following: Bleeding gums Chew on one side of mouth Dry mouth Food collection between teeth Foreign objects Jaw pain or tiredness Mouth breathing Sensitivity to cold treatment Sensitivity to	TORY te	Blisters on lips or mouth \(\times \) No Cigarette, pipe or cigar smoking \(\times \) Yes \(\times \) No Chewing tobacco \(\times \) Yes \(\times \) No Chewing tobacco \(\times \) Yes \(\times \) No Chewing tobacco \(\times \) Yes \(\times \) No Chewing tobacco \(\times \) Yes \(\times \) No Chewing tobacco \(\times \) Yes \(\times \) No Chewing tobacco \(\times \) Yes \(\times \) No Chodontic treatment \(\times \) Yes \(\times \) No Sensitivity when biting \(\times \) Yes \(\times \) No Sensitivity when biting \(\times \) Yes \(\times \) No Medium Have you ever had a serious or difficult problem associated with	0 0 0 0 0 0 0 0 0 0