

WELCOME TO BEDMINSTER FAMILY & COSMETIC DENTISTRY

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we must know as much about the individual as we do about your teeth. No two people are the same; no two mouths are alike. All information, of course, will be held in strict confidence.

Registration and Insurance Information (SECTION A)

Mr. _____ Date of Birth _____
Mrs. _____
Miss _____ First _____ Last _____

Home Address _____ City _____ State _____ Zip _____

Home Phone No. _____ Cell Phone No. _____ E-Mail _____

Social Security No. _____ City _____ State _____

For what company do you work? _____ Do you have DENTAL INSURANCE where you work? _____

Your Business Phone _____ Address _____

Insurance Co. _____ Group No. _____

Phone# _____

IF MARRIED:
Name of Husband/Wife _____ His/Her Occupation _____

For what Company does Spouse work? _____ City _____ State _____

Spouse's Business Phone No. _____ Extension _____

Does Spouse have DENTAL INSURANCE at work? _____

Are you covered under Spouse's DENTAL PLAN? _____ If yes, please give us:
Name of Spouse's DENTAL INSURANCE COMPANY _____

Spouse's Social Security Number _____ Spouse's B-Day _____

How long has it been since your last DENTAL EXAMINATION? _____

Whom may we thank for referring you to our office? _____

MEDICAL HEALTH HISTORY

General health (Please Check) Excellent good fair poor

Please Check if you have had or being treated for:

Heart Disease—Pls Specify _____ Tuberculosis – Date _____

Rheumatic fever Typhoid

Heart Murmur Anemia

Stroke Epilepsy

Liver Disease Ulcers

Hepatitis – Date _____ Cancer

Kidney Disease Diabetes

Venereal Disease—Date _____ Artificial Replacement of any kind (Specify) _____

Asthma Disease of the Immune System (AIDS)

Emphysema

Please Check if you are allergic to:

Penicillin Fluoride

Novocaine Aspirin

Codeine Other _____

Signature _____ Date _____

Date of last complete Physical Exam _____

Is your blood pressure (Please Check)

High Low Normal

Do you take blood pressure medication? _____

Have you had recent surgery? _____ Date _____

Are you being treated for anything now? _____

Please Specify _____

Are you taking medications now? _____

If so, what? _____

Are you subject to prolonged bleeding? _____

Do you have problems with digestion? _____

Do you smoke? Yes _____ No _____

Have you ever been treated with radiation? _____

**FEMALE PATIENTS—Please answer the following:

Are you pregnant? _____

Are you taking birth control pills? _____

Physician's Name _____

Address _____

Phone _____

PARENT DENTAL HISTORY

Date of last dental exam _____

What concerns you most _____

Are you aware of grinding or clenching your teeth? _____ **Yes** **No**

Do you have "clicking" in the ear region? _____

Do you lose fillings or break fillings? _____

Are your teeth sensitive to hot, cold, sweets or during chewing? _____

Does food wedge between certain teeth? _____

Have you ever been under a decay prevention program? _____

Do you use dental floss? _____

Do your gums bleed easily? _____

Do you ever notice a foul taste in your mouth? _____

Would you like to be notified by this office for future prevention checkups to maintain your dental health? _____

What do you think of the condition of your mouth? _____

Excellent Good Fair Poor

What did your previous dentist do to make you feel comfortable? _____

Why did you leave your previous dentist? _____

What do you dislike most about a dental visit? _____

Please add anything important _____

ANALYZE YOUR SMILE

Yes **No**

1. Do you like the color of your teeth? _____
2. Do you have spaces between your teeth? _____
3. Are you upper front teeth straight? _____
4. Are your two upper front teeth slightly longer than adjacent teeth? _____
5. Are your teeth free of discolored areas? _____
6. If your front teeth have filling, do they match the color of your teeth? _____