Robbie L. Baxter, D.D.S.
Comprehensive Cosmetic Dentistry

Today's Date _____

Purpose of Visit _____

GENERAL INFORMATION

Dr., Mr., Mrs., Miss, Ms. _____ Birthdate _____
Last First Middle

Parent's or Guardian's Name, if patient is a minor _____

Residence address _____
Number Street

_____ Phone ( ) _____
City State Zip Area Code

If less than one year, previous address _____

Occupation _____ Employer _____ # of years_____

Business Address _____
Street City State Zip Phone

Social Security # ___ ___ _____ Marital Status _____ Name of Spouse _____

Number of Dependents _____ Spouse's Occupation_____

Spouse's Employer_____
Name of Employer Address

Person Financially Responsible (if other than patient) _____

In case of Emergency, nearest relative not living with you _____
Name

_____
Relationship Address Phone

Referred by _____ When _____

Are you a member of a pre-paid dental plan? YES ◯ NO ◯ If answer is yes, please complete Insurance Information section below.

INSURANCE INFORMATION If you have any type of dental insurance, please complete

Name of Insurance Company_____

Name of Dental Plan _____ Group Number _____

Employee Name _____ Employee Social Security # ___ ___ _____

Patient name_____

Relationship to Employee _____ Patient's birthdate _____

Employer _____

Employer's Address _____
Street City State Zip Phone

Union Local # _____ Address _____

Has patient had previous dental care under this plan?_____

Approximate date patient coverage began _____

Does your insurance cover diagnostic services ?	Yes ◯	No ◯	Don't Know ◯
Does your insurance cover restorative treatment ?	Yes ◯	No ◯	Don't Know ◯

MEDICAL HISTORY

Name of Physician _____ City _____ Phone _____

Do you have a current medical problem? Yes ○ No ○ What _____

Have you ever had any of the following:

YES	NO		YES	NO	
○	○	Lung trouble (TB, asthma, emphysema)	○	○	Swelling of ankles or feet
○	○	Hepatitis, liver disease, jaundice	○	○	Pain, pressure or tightness in chest
○	○	Arthritis, sore joints	○	○	Heart attack
○	○	Diabetes	○	○	Rheumatic fever
○	○	Excessive Bleeding	○	○	Heart Murmur
○	○	Blood trouble, anemia, leukemia	○	○	High blood pressure
○	○	VD (syphillis, gonorrhea, etc.)	○	○	Fainting spells, convulsions, epilepsy
○	○	X-ray, indium, cobalt treatments	○	○	Headaches when lying down
○	○	Shortness of breath	○	○	Glaucoma
○	○	Positive HIV test	○	○	Nervous breakdown, psychotherapy

Are you now:

○	○	Pregnant or nursing a child	○	○	Using Dilantin
○	○	Using Thyroids	○	○	Using Other medicines (please specify)
○	○	Using hormones (including birth control)			Medicine For
○	○	Using anticoagulents			_____
○	○	Excessive Bleeding			_____
					_____

Are you now taking or using medicines for:

○	○	Diabetes (pills or shots)	○	○	Blood (liver, iron pills, blood thinners)
○	○	Nerves (tranquilizers)	○	○	Stomach trouble (ulcer, other)
○	○	Sleeping	○	○	Headaches
○	○	Heart or blood pressure	○	○	Arthritis or rheumatism
○	○	(digitalis, nitroglyerin, resorpin)	○	○	Allergy

Have you ever been sick from, shown an allergy to, or told not to take

○	○	Antibiotics	○	○	Novocaine (or other dental anesthetic)
○	○	Pain medications	○	○	Other drugs or medicines (please specify)
○	○	Narcotic drugs			_____
○	○	Aspirin			_____

Have you ever had a tumor or cancer? Yes ○ No ○ Where? _____

Have you ever had a major operation? Yes ○ No ○ What kind? _____

Have you ever been involved in a serious accident? Yes ○ No ○ Describe: _____

Comments: _____

_____

_____

_____

MEDICAL HISTORY

	YES	NO
Following injuries, have you ever had bleeding problems?	○	○
Do injuries and cuts take longer to heal now than previously?	○	○
Have you had eye trouble recently?	○	○
Do you urinate more than 6 times a day?	○	○
Have you recently lost weight unintentionally?	○	○
Is there a history of diabetes in your family?	○	○

Date of last medical exam _____
month year

DENTAL HISTORY

	YES	NO
Have you come to this office for relief of pain?	○	○
If YES, where is the pain? _____		
Have you had the pain more than 3 weeks?	○	○
Are you presently having dental pain?	○	○
Have you had orthodontic treatment?	○	○
Do you have unreplaced missing teeth?	○	○
If YES, why haven't you had them replaced? _____		
Was it ever suggested?	○	○
Do you have difficulty swallowing?	○	○
Do your gums bleed when brushing your teeth?	○	○
Have you ever been told you have pyorrhea?	○	○
Have you ever had professional instructions on dental home care?	○	○
Is any part of your mouth sensitive to temperature, or pressure?	○	○
If YES, which part? _____		
Does food catch between your teeth?	○	○
If YES, where? _____		
Do you have any pain or soreness around the eyes, or ears?	○	○
Do you have any unpleasant odor, or taste, in your mouth?	○	○
Do you always have something to be treated or repaired when you visit a dentist?	○	○
Do you feel that in the past you have required a lot of dental work?	○	○
If YES, has it been to replace previous dentistry, or to repair a new decay?	Replace ☐	New Decay ☐
Do you feel that you will lose more teeth and eventually have to wear full dentures?	○	○
If so, at what age? _____		
Are you deeply concerned about the finances required to return your mouth to dental health?	○	○

ESTHETIC EVALUATION

Please circle the appropriate answer

	YES				NO
Are you satisfied with your teeth and their appearance?	5	4	3	2	1
Are you self-conscious about your teeth when you smile?	5	4	3	2	1
Do you ever cover your smile with your hand?	5	4	3	2	1
Do you wish your teeth were whiter?	5	4	3	2	1
Do you wish your teeth were shaped differently?	5	4	3	2	1
Do you have any discolored teeth?	5	4	3	2	1
Have esthetic dental procedures ever been recommended to you?	5	4	3	2	1

OCCLUSAL SCREENING

	YES	NO
1. Do you clench or grind your teeth during the day?	○	○
2. Have you been made aware of clenching or grinding your teeth during the night?	○	○
3. Do you have chronic headaches, or neck and shoulder pains?	○	○
4. Are your jaws or teeth tired when you awaken?	○	○
5. Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)?	○	○
6. Have your jaws ever clicked or popped when you open your mouth?	○	○
7. Have you ever experienced difficulty moving your jaw or opening your mouth wide?	○	○
8. Do you chew on only one side of your mouth?	○	○

DENTURES

	YES	NO
Do any of your family, including your parents, wear dentures?	○	○

How many dentures do you wear? _____

How long have you worn dentures? _____

Why were your teeth extracted? _____

If you are currently having a denture problem, is it related to:

Pain ○ Discomfort ○ Appearance ○ Function ○

I have completed this preclinical examination questionnaire to the best of my knowledge and agree to treatment.

Signature _____ Date _____
(Parent if patient is a minor)

Received & witnessed by _____ Date _____ Reviewed by Dr. _____ Date _____