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:

YES	NO		YES	NO	
◯	◯	Pregnant or nursing a child	◯	◯	Using Dilantin
◯	◯	Using Thyroids	◯	◯	Using Other medicines (please specify) Medicine For
◯	◯	Using hormones (including birth control)			______________________
◯	◯	Using anticoagulents			______________________
◯	◯	Excessive Bleeding			______________________

Are you now taking or using medicines for:

YES	NO		YES	NO	
◯	◯	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

YES	NO		YES	NO	
◯	◯	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 ________