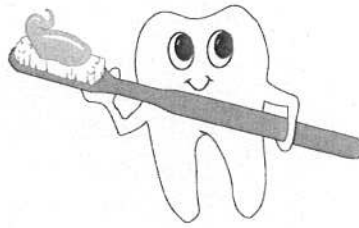


# Cosmetic, Implant and Family Dentistry

Howard A. Zetlan D.M.D.  
Bruce J. Rubin D.M.D.  
Carol S. Rice D.M.D.

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Dracut, MA 01826  
Telephone 978-957-4747  
Fax 978-957-5662

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.



Patient # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Date \_\_\_\_\_

Home Phone \_\_\_\_\_

## *Patient Information (Confidential)*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Full Time \_\_\_ Part Time \_\_\_

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

May we call you at work regarding your appointments? \_\_\_\_\_

Email Address \_\_\_\_\_ Would you rather a confirmation call or email?

Whom May We Thank for Referring You? \_\_\_\_\_

## *Insurance Information*

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ ID # \_\_\_\_\_ Social Security \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group \_\_\_\_\_ Policy / ID # \_\_\_\_\_

# Patient Information

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   |   |
|---|---|
| <p>1. Are you under medical treatment now? If yes, for what? <span style="float: right;">Yes No<br/><input type="checkbox"/> <input type="checkbox"/></span></p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain. <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>_____</p> <p>_____</p> <p>4. Do you use tobacco? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>5. Do you use controlled substances? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>6. Are you wearing contact lenses? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> | <p>7. Are you allergic to or have you had any reactions to the following? <span style="float: right;">Yes No</span></p> <p>Local Anesthetics (e.g. novocaine) <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Penicillin or any other Antibiotic <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Sulfa Drugs <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Barbiturates <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Sedatives <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Iodine <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Aspirin <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Any Metals (e.g. nickel, mercury, etc.) <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Latex Rubber <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Other (please list) <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>8. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>b. Are you nursing? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>c) Are you taking oral contraceptives? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> |
|---|---|

## Medical History

Do you have or have you had any of the following?

- |  |                          |                          |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
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| <table border="0"> <tr><td>High Blood Pressure</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Heart Attack</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Rheumatic Fever</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Swollen Ankles</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Fainting/Seizures</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Asthma</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Low Blood Pressure</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Epilepsy/Convulsions</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Leukemia</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Diabetes</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Kidney Diseases</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>AIDS or HIV Infection</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Thyroid Problem</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | High Blood Pressure      | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | <table border="0"> <tr><td>Heart Disease</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cardiac Pacemaker</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Heart Murmur</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Angina</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Frequently Tired</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Anemia</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Emphysema</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cancer</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Joint Replacement or Implant</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hepatitis/Jaundice</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Sexually Transmitted Disease</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Stomach Troubles/Ulcers</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <table border="0"> <tr><td>Chest Pains</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Easily Winded</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Stroke</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hay Fever/Allergies</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Tuberculosis</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Radiation Therapy</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Glaucoma</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Recent Weight Loss</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Liver Disease</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Heart Trouble</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Respiratory Problems</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Mitral Valve Prolapse</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Heart Attack   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Rheumatic Fever  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Swollen Ankles   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Fainting/Seizures  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Asthma   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Low Blood Pressure   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Epilepsy/Convulsions   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Leukemia   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Diabetes   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Kidney Diseases  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| AIDS or HIV Infection  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Thyroid Problem  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Heart Disease  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Cardiac Pacemaker  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Heart Murmur   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Angina   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Frequently Tired   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Anemia   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Emphysema  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Cancer   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Joint Replacement or Implant   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Hepatitis/Jaundice   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Sexually Transmitted Disease   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Stomach Troubles/Ulcers  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Chest Pains  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Easily Winded  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Stroke   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Hay Fever/Allergies  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Tuberculosis   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Radiation Therapy  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Recent Weight Loss   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Liver Disease  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Heart Trouble  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Respiratory Problems   | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Mitral Valve Prolapse  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |
| Other  | <input type="checkbox"/> | <input type="checkbox"/> |                          |              |                          |                          |                 |                          |                          |                |                          |                          |                   |                          |                          |        |                          |                          |                    |                          |                          |                      |                          |                          |          |                          |                          |          |                          |                          |                 |                          |                          |                       |                          |                          |                 |                          |                          |   |               |                          |                          |                   |                          |                          |              |                          |                          |        |                          |                          |                  |                          |                          |        |                          |                          |           |                          |                          |        |                          |                          |                              |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |  |             |                          |                          |               |                          |                          |        |                          |                          |                     |                          |                          |              |                          |                          |                   |                          |                          |          |                          |                          |                    |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |                       |                          |                          |       |                          |                          |

# Patient Dental History

Name of Previous Dentist \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel you have pain in any of your teeth?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw?                         |                          |                          |
| Clicking  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face)   | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing  | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you clench or grind your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you bite your lips or cheeks frequently?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had any difficult extractions in the past?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any prolonged bleeding following extractions?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had any orthodontic treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you wear dentures or partials?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date of replacement _____   |                          |                          |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you like your smile?   | <input type="checkbox"/> | <input type="checkbox"/> |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
Signature of patient (or parent if minor)

What is the reason for today's visit? \_\_\_\_\_

Would you be interested in whitening your teeth? \_\_\_\_\_

Would you prefer silver fillings for your teeth? \_\_\_\_\_

Do you participate in active sports? \_\_\_\_\_ Do you wear a mouthguard? \_\_\_\_\_

Are you concerned about your breath? \_\_\_\_\_

Is there anything about your teeth you would like to change? \_\_\_\_\_

Do you have any likes or dislikes from your previous dental experiences that you would share with us?  
\_\_\_\_\_

