Style Your Smile Family and Cosmetic Dentistry

46 Village Court, Hazlet, NJ 07730 Tel: 732-335-553

REGISTRATION AND HEALTH HISTORY

Name			Single	Married	Divorced	Separated	Widowed
Social Security number	Birthdate		Home Phone		Business Phone	
Residence address	City		State	Zip		
Employed by	City		State	Zip		
Present position	How long held		Your driver license no.		State	
Spouse Name						
Spouse Social Security number			Spouse birthdate		Business phone	
Spouse employed by	City		State	Zip		
Present position	How long help		Spouse driver license no.		State	
Referred by			Address			
Who will pay for this account?	Credit card name		No. Expiration date			
Name of your dental insurance						
Union local	Group no.		Policy no.			
Name of your spouse's dental insurance company						
Union local	Group no.		Policy no.			

It is important that I know your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission

Your Dental History

Are you having any discomfort at this time_____
How long since you have been to a dentist_____
What was done then_____
Did you have X-Rays_____
How often did you visit a dentist before then_____
Have you lost any teeth_____
Why_____
Any complications with extraction_____
Have there ever been replaced by: () A Fixed Bridge_____
(2) Removable Partial_____(3) Denture4_____
How many of (1) (2) (3)_____
Are your teeth sensitive to heat_____ cold_____ sweets_____ sour_____
Have you had your teeth straightened_____ When_____
How often do you brush your teeth_____ When_____
How_____

How long do you use a toothbrush before replacing it_____
Do you use dental floss_____ How often_____
Between-the-teeth stimulator_____ Water jet_____
Do you have bleeding gums_____ When_____
_____
Do you eat between meals_____ Do you brush teeth after snacks ____
Does food wedge between your teeth_____
Where_____
Do you grind or clench your teeth_____
When_____
Have you ever had gum treatment_____ When_____
Do you feel you have bad breath at times_____
Unpleasant test in mouth_____
Any pain in or your ears_____
Do you hear popping, clicking or snapping noise when you chew_____
Do you have any nasal obstruction_____
Are you aware of any swelling or lump in your mouth_____

Do you now have or have you had any of the following habits: Thumbsucking_____ Fingersucking_____

Cheek or tongue chewing_____ Chewing on Pencils_____ Pens_____ Lips_____

Fingernails_____

Do you have fear of any dentistry done_____ If YES, why_____

How do you feel about your teeth_____

How do you feel about dentures_____

Do you want to avoid the dental discomfort you may have experienced in the past_____

Do you want to avoid dentures_____

Do you want to have a pleasant breath_____

Do you want to know how you can keep e natural teeth you still have_____

If you have children, do you want to learn how they may keep their natural teeth for a lifetime without discomfort_____

Your Medical History

Physician's Name_____ Date of last physical exam_____

Birthdate_____ Age_____

Do you have or have you had any of the following. Please indicate with a check mark (✓)

___Any heart problems
___High blood pressure
___Low blood pressure
___Circulatory problems
___Nervous problems
___Radiation treatments
___Excessive bleeding
___AIDS

___Allergies to anesthetics
___Allergies to medicines or drugs
___Allergies to_____
___Anemia
___Arthritis
___Asthma
___Diabetes

___Hepatitis
___Herpes
___Malignancies
___Measles
___Mumps
___Psychiatric care
___Rheumatic Fever
___Scarlet Fever

___Sinus Problems
___Stroke
___Typhoid Fever
___Tonsillitis
___Tuberculosis
___Ulcer
___Venereal Diseases
___Other

Are you pregnant_____ Blood Pressure: S_____/D_____/_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment:

_____

_____

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Date_____ Your signature_____