MEDICAL HISTORY

	YES	NO
Do you have any general health problems?	❒	❒
If so, please specify_____		
Are you currently under a physician's care?	❒	❒
Reason_____		

Name and Address of Physician

_____

Are you currently taking any drugs or medication? Blood thinners?	❒	❒
If so, what?_____		

To the best of your knowledge, are you or have you ever been afflicted with

Heart Ailment	❒	❒
Diabetes	❒	❒
Epilepsy	❒	❒
High Blood Pressure	❒	❒
Respiratory Disease	❒	❒
Hepatitis/HIV	❒	❒
Prolonged Bleeding	❒	❒
Healing Complication	❒	❒
Allergy to any Drug(s) Which _____	❒	❒
Would you like us to take your blood pressure?	❒	❒

Why did you leave your last dentist?

_____

SIGNATURE _____

Ken Mannas DDS

"A lifetime of Excellent Dental Care Begins With Your First Visit"

DATE _____

NAME _____

ADDRESS _____

CITY, ZIP _____

PHONE _____ CELL _____

EMAIL _____

DATE OF BIRTH _____

OCCUPATION _____

EMPLOYER _____

ADDRESS _____

_____ PHONE _____

MARITAL STATUS _____

SPOUSE'S NAME _____

SPOUSE'S PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

_____

(OVER PLEASE)

DENTAL INSURANCE INFORMATION:

Name of Carrier _____

Subscriber's Name _____

Subscriber's Birthdate _____

Subscriber's SSN _____

Insurance ID _____

Phone Number _____

DENTAL HISTORY

	YES	NO
1. Are your teeth sensitive to:		
Heat?	❒	❒
Cold?	❒	❒
Sweets?	❒	❒
Biting Pressure?	❒	❒
2. Does food constantly get stuck between certain teeth in your mouth?	❒	❒
3. Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	❒	❒
4. Are you dissatisfied with your teeth in any way?	❒	❒
5. Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc.	❒	❒
6. Do you have any fillings that show in your front teeth?	❒	❒
7. Do any of your fillings show when you smile?	❒	❒
8. If any of your mercury amalgam filings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?	❒	❒
9. Have you ever had any teeth removed?	❒	❒
10. How long have these teeth been missing?_____		
11. Do your gums bleed when brushing?	❒	❒
12. Do you ever avoid any part of the mouth while brushing?	❒	❒
13. Have you been instructed regarding proper home care?	❒	❒
14. Do you have an unpleasant taste or odor in your mouth?	❒	❒
15. Do you smoke?	❒	❒
16. Do you frequently snack between meals on sweets or chew gum?	❒	❒
17. How often do you brush your teeth?_____		
18. How often do you use floss?_____		
19. Do you want to learn to control dental disease and retain your teeth?	❒	❒
20. Has the fear of discomfort kept you from regular dental visits?	❒	❒
21. Are you deeply concerned about the finances required to return your mouth to excellent dental health?	❒	❒
22. When was your last dental appointment?_____		
23. What did you have done?_____		
24. How long since your last *thorough* examination with *full mouth x-rays*?_____		
25. What prompted you to seek care at this time?		

_____

REMARKS