

**CENTER FOR AESTHETIC DENTISTRY**  
Pittsburgh, Pennsylvania - 412-344-7755  
*We would like to get to know you better!*

DATE \_\_\_\_\_

NAME \_\_\_\_\_

RESIDENCE \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

SPOUSE'S OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

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Person financially responsible for this account \_\_\_\_\_

Social Security Number \_\_\_\_\_

Do you have a dental benefit plan? \_\_\_\_\_

If yes, carrier \_\_\_\_\_

## DENTAL HISTORY

	YES	NO
1). Are your teeth sensitive to:		
Heat?	<input type="checkbox"/>	<input type="checkbox"/>
Cold?	<input type="checkbox"/>	<input type="checkbox"/>
Sweet?	<input type="checkbox"/>	<input type="checkbox"/>
Biting Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2). Does food constantly get stuck between certain teeth in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
3). Do you get frustrated because you always have something to be treated or repaired when you have to visit a dentist?	<input type="checkbox"/>	<input type="checkbox"/>
4). Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc.	<input type="checkbox"/>	<input type="checkbox"/>
5). Are you dissatisfied with your teeth in any way?	<input type="checkbox"/>	<input type="checkbox"/>
6). Do you have any fillings that show in your front teeth?	<input type="checkbox"/>	<input type="checkbox"/>
7). Do any of your fillings show when you smile?	<input type="checkbox"/>	<input type="checkbox"/>
8). If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth colored restoration instead?	<input type="checkbox"/>	<input type="checkbox"/>
9). Have you ever had any teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>
10). How long have these teeth been missing? _____		
11). Have you been told you have frequent, heavy snoring?	<input type="checkbox"/>	<input type="checkbox"/>
12). Have you been told you stop breathing while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
13). Do you have morning headaches?	<input type="checkbox"/>	<input type="checkbox"/>
14). Are you aware of any teeth grinding at night?	<input type="checkbox"/>	<input type="checkbox"/>
15). Do you wear a CPAP?	<input type="checkbox"/>	<input type="checkbox"/>

If so, when did you start wearing it? \_\_\_\_\_

	YES	NO
16). Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>
17). Do you ever avoid any part of the mouth while brushing?	<input type="checkbox"/>	<input type="checkbox"/>
18). Have you ever been instructed regarding proper home care?	<input type="checkbox"/>	<input type="checkbox"/>
19). Do you have an unpleasant taste or odor in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
20). Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
21). Do you frequently snack between meals on sweets or chew gum?	<input type="checkbox"/>	<input type="checkbox"/>
22). How often do you brush your teeth? _____		
23). How often do you use floss? _____		
24). Do you want to learn to control dental disease and retain your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
25). Has the fear of discomfort kept you from regular dental visits?	<input type="checkbox"/>	<input type="checkbox"/>
26). Are you deeply concerned about the finances required to return your mouth to excellent dental health?	<input type="checkbox"/>	<input type="checkbox"/>
27). When was your last dental appointment? _____		
28). What did you have done? _____		
29). How long since your last <i>thorough</i> examination with <i>full mouth x-rays</i> ? _____		
30). What prompted you to seek dental care at this time? _____ _____		

REMARKS

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**MEDICAL HISTORY**

	YES	NO
Do you have any general health problems? If so, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently under a physician's care? Reason _____ Name and address of Physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any joint (heart valve, knee, hip, etc.) replacement?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any drugs or medication? If so, what? _____	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge, are you or have you ever been afflicted with		
Heart Ailment – Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur, Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Healing Complication	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to any Drugs or Latex	<input type="checkbox"/>	<input type="checkbox"/>
Would you like us to take your blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>

Why did you leave your last dentist? \_\_\_\_\_

I authorize the use of radiographs, photographs, or videotapes of my

case for use in presentations or publications of the doctor.

SIGNATURE \_\_\_\_\_