

Welcome to Majestic Dentistry

We are honored that you have chosen our practice. Please help us get acquainted with you.

First Name _____ Middle Initial _____ Last Name _____ Date _____

I prefer to be called _____ Male Female Single Married Divorced Widowed

Street Address: _____ Apt/Ste # _____

City _____ State _____ Zip Code _____

Home Phone # () _____ Cell # () _____ Work # () _____

Email Address: _____ Date of Birth _____ Age _____

Who may we thank for referring you to our practice? _____

What is your Business or Occupation? _____

What do you like to do for fun (Hobbies/Interests) _____

Spouse/partner's name _____ Do you have children? Yes No If so, How many _____

Please list the names and ages of your children.

_____ Age _____ _____ Age _____ _____ Age _____

_____ Age _____ _____ Age _____ _____ Age _____

Please list the names and ages of your grandchildren.

_____ Age _____ _____ Age _____ _____ Age _____

_____ Age _____ _____ Age _____ _____ Age _____

Do you have pets? Yes No What type? Dog Cat Bird Other _____

Please list the names and types of pets you own.

_____ Type _____ _____ Type _____ _____ Type _____

_____ Type _____ _____ Type _____ _____ Type _____

Briefly, please tell us the reason for your first visit with us. _____

DENTAL HISTORY

Have you ever experienced any adverse reaction to past dental care? Yes No

If yes, please explain _____

When was your last visit to a dentist? _____ Name of previous dentist? _____

What did you like most about your last dentist? _____

What did you least like about your last dentist? _____

What made you decide to leave your previous dentist? _____

How often do you visit the dentist to have your teeth cleaned? 3 mo. 6 mo. 1 yr. Longer

How often do you brush? _____ x a day How often do you floss? _____

On a scale from 1 to 10, with 10 being completely healthy and ideal, how would you rate your oral health?

Please circle. 1 2 3 4 5 6 7 8 9 10

How important is it to you to keep your teeth healthy and looking good for your lifetime?

Extremely important Somewhat important Not that important

On a scale from 1 to 10, with 10 being extremely fearful and nervous, please rate your level of fear and/or anxiety regarding your dental care.

Please circle 1 2 3 4 5 6 7 8 9 10

If you could change anything about your smile or your teeth, what would it be? Please check all that apply.

- Whiter Straighter Close Spaces Replace dark fillings with natural looking fillings
- Even out Size or shape Replace missing teeth Replace partial or full dentures

Are you experiencing any of the following: Please check all that apply.

- Clicking, popping or locking jaw Grinding or clenching Jaw pain Loose teeth
- Periodontal (gum) disease Sensitivity to Hot/Cold Sensitivity when biting
- Tension Headaches Awaken with awareness of your teeth/jaw Broken/loose fillings
- Sensitivity when brushing Smoker or Tobacco User Bad breath Bleeding gums
- Too much of my gums show when I smile

MEDICAL HISTORY

Have you ever needed to take or told that you needed to take antibiotics prior to your dental appointments? Yes No

Please rate your general health. Excellent Good Fair Poor

Are you currently under a physician's care? Yes No Date of most recent physical exam _____

Physician Name _____ Physician Phone # _____

Have you ever had an allergic reaction to any of the following? Please check all that apply.

- Latex Penicillin Local Anesthetic Codeine Aspirin Tylenol Ibuprofen Other _____

Do you have or have you ever had any of the following? Please check all that apply.

- Heart Problems Artificial Prosthesis (Heart Valve, Hip or Knee Replacement) Digestive Disorders
- Chemotherapy Mitral Valve Prolapse Diabetes Emotional Problems
- Arthritis HIV/AIDS Psychiatric Treatment Heart Murmur
- Epilepsy, Convulsions, Seizures Viral Infections or Cold Sores High Blood Pressure
- Stroke Hepatitis (Type____) Alcohol Dependency Prolonged Bleeding
- Hay Fever Cancer Drug Dependency Asthma
- Sinus Congestion Radiation Therapy Anti-depressant medication Rheumatic Fever
- Eating Disorder Thyroid Disease

WOMEN: Are you pregnant? Yes No Are you taking birth control Pills? Yes No

Please list all medications you are currently taking and reason for taking them.

- Medication _____ For _____ Medication _____ For _____
- Medication _____ For _____ Medication _____ For _____
- Medication _____ For _____ Medication _____ For _____
- Medication _____ For _____ Medication _____ For _____

Please describe any current medical treatment you are undergoing or any impending surgical procedures. _____
