J. Marc Holser, DDS

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REGISTRATION AND INSURANCE INFORMATION

Name	Preferred Name	Birthday	Social Security Number

Address	City	State	Zip Code

Home Phone	Business Phone	Cell Phone

Email Address	Best Time to Call: Morning Evening Anytime

Patient Employer	City	State	Zip Code

Emergency Contact	Emergency Contact Phone Number	Relationship to Patient

Referred By	Address

Dental Insurance Policy Holder's Name	Relationship to Patient

Policy Holder's Social Security Number	Policy Holder's Birthday	Policy Holder's Address (if different than patient)

Insurance Company Name

Policy Holder's Employer	City	State	Zip Code

It is important that I know about 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? ☐ Yes ☐ No
  If yes, where? ______________________
- When was your last dental visit? ______________________
- Are your teeth sensitive to: ☐ Heat ☐ Cold ☐ Sweet
- Have you had your teeth straightened? ☐ Yes ☐ No
  If yes, when? ______________________
- Do you have bleeding gums? ☐ Yes ☐ No
  If yes, when? ______________________
- When and how do you brush your teeth? ______________________
- How do you clean between your teeth? ☐ Floss ☐ Toothpick ☐ Waterpick ☐ I don't
- Tobacco use? ☐ Yes ☐ No
- Does food wedge between your teeth? ☐ Yes ☐ No
  If yes, where? ______________________
- Do you grind or clench your teeth? ☐ Yes ☐ No
  If yes, when? ______________________

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- Have you ever had gum treatments? ☐ Yes ☐ No
  If yes, when? ____________________
- Do you hear popping clicking or snapping noises when you chew? ☐ Yes ☐ No
- Are you aware of any swelling or lump in your mouth? ☐ Yes ☐ No
- Any bad experiences during a dental visit? ☐ Yes ☐ No
- How do you feel about your teeth? ____________________

MEDICAL HISTORY

Physicans Name	Date of Last Physical Exam

Please indicate which of the following you have had or have at present.

☐ Allergy Latex	☐ Artificial Joints	☐ Asthma	☐ Blood Disease	☐ Chemotherapy
☐ Diabetes	☐ Dry Mouth	☐ Eating Disorders	☐ Excessive Bleeding	☐ GERD
☐ Head Injuries	☐ Headaches	☐ Heart Disease	☐ Heart Murmur	☐ High Blood Pressure
☐ Osteoporosis	☐ Pacemaker	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Sinus Problems
☐ Stroke	☐ Tobacco Use			

- If any condition or alerts selected above or not listed needs futher clarification, please describe below:

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____

- List Medication Allergies:

____

____

- Please describe any current medical treatment:

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____

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- Do you take antibiotics for your dental visits? ☐ Yes ☐ No
  If yes, please explain. ____________________
- List all medications:

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