

Chris Stanosheck, DDS

402.884.1607
www.drstano.com

*We would like to get
to know you better!*

Dental History

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are your teeth sensitive to: | | |
| Heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold? | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweets? | <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 visit a dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you dissatisfied with your teeth in any way? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you dissatisfied with the way your teeth look? For example: color, shape spaces, etc. | <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. Do your gums bleed when brushing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you avoid any part of the mouth while brushing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you been instructed regarding proper home care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have an unpleasant taste or odor in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |

Dental History (continued)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 16. Do you frequently snack between meals on sweets or chew gum? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has the fear of discomfort kept you from regular dental visits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you deeply concerned about the finances required to return your mouth to excellent dental health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. When was your last dental appointment? _____ | | |
| 23. What did you have done? _____ | | |
| 24. How long since your last <i>thorough</i> examination with <i>full mouth x-rays</i> ? _____ | | |
| 25. What prompted you to seek dental care at this time?
_____ | | |
| 26. How healthy do you want us to get your mouth?
<input type="checkbox"/> Don't really care
<input type="checkbox"/> Average
<input type="checkbox"/> The best it can be | | |
| 27. At what point do you want us to initiate treatment?
<input type="checkbox"/> When my tooth hurts or breaks
<input type="checkbox"/> When something is worsening
<input type="checkbox"/> When something is not ideal | | |
| 28. What quality of dentistry do you want us to recommend?
<input type="checkbox"/> Don't really care
<input type="checkbox"/> Average
<input type="checkbox"/> The best it can be | | |
| 29. What would you like to change about your smile?

_____ | | |
| 30. What caused you to leave your last dental office?

_____ | | |

REMARKS

Medical History

Yes No

Do you have any general health problems? Yes No

If so, please specify _____

Are you currently under a physician's care? Yes No

Reason _____

Name and Address of Physician _____

Are you currently taking any drugs or medication? Yes No

If so, what? _____

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

Heart Ailment Yes No

Diabetes Yes No

Rheumatic Fever Yes No

Epilepsy Yes No

High Blood Pressure Yes No

Respiratory Disease Yes No

Hepatitis Yes No

Prolonged Bleeding Yes No

Healing Complication Yes No

SIGNATURE _____

Client Information

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Cell Phone _____

Home Phone _____

Work Phone _____

(Please check your preferred method of communication)

Occupation _____

Employer _____

Employer Address _____

Date of Birth _____

Social Security Number _____

Marital Status _____

Spouse's Name _____

Spouse Employer _____

Emergency Contact _____

Preferred Pharmacy _____

Person financially responsible for this account

Do you have a dental benefit plan? Yes No

If yes, carrier _____

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