

L I N D S E Y M A R S H A L L

D M D

Ardmore Pennsylvania
610.649.0696 www.lindseymarshall.com

We would like to get
to know you better!

Name _____ Date _____

Residence _____

Phone _____

Occupation _____

Employer _____

Address _____

Phone _____

Email Address _____

Date of Birth _____

Social Security Number _____

Marital Status _____

Spouse's Name _____

Spouse's Occupation _____

Employer _____

Address _____

Phone _____

Whom may we thank for referring you? _____

Person financially responsible for this account: _____

Dental History

	YES	NO		YES	NO
1. Are your teeth sensitive to:			15. Have you been instructed regarding proper home care?	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you have an unpleasant odor or taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets	<input type="checkbox"/>	<input type="checkbox"/>	18. Do you frequently snack between meals on sweets or chew gum?	<input type="checkbox"/>	<input type="checkbox"/>
Biting Pressure	<input type="checkbox"/>	<input type="checkbox"/>	19. How often do you brush your teeth? _____		
2. Does food constantly get stuck between certain teeth in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	20. How often do you floss? _____		
3. Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?	<input type="checkbox"/>	<input type="checkbox"/>	21. Do you want to learn to control dental disease and retain your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you dissatisfied with your teeth in any way?	<input type="checkbox"/>	<input type="checkbox"/>	22. Has the fear of discomfort kept you from regular dental visits?	<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"/>	23. Are you deeply concerned about the finances required to return your mouth to excellent dental health?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have fillings that show in your front teeth?	<input type="checkbox"/>	<input type="checkbox"/>	24. When was your last dental appointment? _____		
7. Do any of your fillings show when you smile?	<input type="checkbox"/>	<input type="checkbox"/>	25. What did you have done? _____		
8. Have you ever had any teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
9. How long have these teeth been missing? _____			26. How long since your last thorough examination with full mouth x-rays? _____		
10. Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>	27. What prompted you to seek dental care this time? _____		
11. Do you ever avoid any part of the mouth while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Remarks _____		
13. Do you have clicking or popping in your jaw joint?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
14. Do you get frequent headaches or neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Medical History

	YES	NO		YES	NO
1. Do you have any general health problems?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
2. If so please specify:			Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
4. Reason: _____			Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Name and address of physician: _____			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
_____			Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
_____			Healing Complication	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently taking any drugs or medication?	<input type="checkbox"/>	<input type="checkbox"/>	Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>
7. If so, what? _____			Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
8. To the best of your knowledge, are you or have you ever been afflicted with:			9. Would you like us to take your blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Ailment	<input type="checkbox"/>	<input type="checkbox"/>	10. Why did you leave your last dentist? _____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Signature _____ Date _____