

Name: _____

Date: _____

How did you hear about our office? _____

Are you interested in cosmetics? _____

Do you have concerns about metals in your mouth? _____

Do you fear dental treatment? _____

Do you wish to have dental material compatibility testing done? _____

What are your main concerns in decreasing order of priority?

1. _____

2. _____

3. _____

Previous dentists:

1. _____ Phone Nr. _____

2. _____ Phone Nr. _____

Your reason for changing dentists: _____

Naturopathic practitioners / chiropractors / physicians you see:

1. _____ Specialty: _____ Phone: _____

2. _____ Specialty: _____ Phone: _____

3. _____ Specialty: _____ Phone: _____

What supplements, herbs, or homeopathic remedies do you take?

Describe briefly what medical or health conditions you suffer from.

Have you taken bisphosphonates (fosamax, etc.) for osteoporosis treatment anytime in the past? _____

Please check if you presently have, or have had any of the following conditions:

- | | |
|--|--|
| <input type="checkbox"/> TMJ (jaw-joint) problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Snoring/sleep apnea | <input type="checkbox"/> Clenching or grinding teeth |
| <input type="checkbox"/> Orthodontic therapy (<input type="checkbox"/> With extraction of 4 sound teeth to create space?) | |
| <input type="checkbox"/> Gum disease | <input type="checkbox"/> Multiple teeth missing |