PATIENT NAME_____

How often do you brush your teeth each day?_____

How often do you floss your teeth?_____

Have you lost any teeth? __No __Yes Why?_____

Have you ever had any complications due to dental treatment you have received? __Yes __No Explain:_____

Do you have: __Fixed Bridge __Removable Partial __Full Denture

How long do you use a toothbrush before replacing it?_____

Would you like to have whiter teeth? __Yes __No

Do you have any fear of dental treatment?_____

How do you feel about your teeth?_____

How do you feel about dentures?_____

What is your current dental health? __Good __Fair __Poor

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

How did you hear of our office?_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and that it is my responsibility to inform this office of any changes in my medical or dental status.

_____ _____
Signature Date

OFFICE USE ONLY BELOW LINE

TREATMENT PLAN

DATE	DIAGNOSIS	TOOTH	SERVICE	APPT. #	COMPLETE

_____ Pos.	Neg.	Date	_____ Pos.	Neg.
( )	( )	Lymphatics	( )	( )
( )	( )	Lips	( )	( )
( )	( )	TMJ	( )	( )
( )	( )	Buccal Mucosa	( )	( )
( )	( )	Tongue	( )	( )
( )	( )	Floor of Mouth	( )	( )
( )	( )	Hard Palate	( )	( )
( )	( )	Soft Palate	( )	( )
( )	( )	Alveolar Ridge	( )	( )
( )	( )	Periodontal Tissues	( )	( )
( )	( )	Mobility	( )	( )
( )	( )	Caries	( )	( )

_____ Pos.	Neg.	Date	_____ Pos.	Neg.
( )	( )	Lymphatics	( )	( )
( )	( )	Lips	( )	( )
( )	( )	TMJ	( )	( )
( )	( )	Buccal Mucosa	( )	( )
( )	( )	Tongue	( )	( )
( )	( )	Floor of Mouth	( )	( )
( )	( )	Hard Palate	( )	( )
( )	( )	Soft Palate	( )	( )
( )	( )	Alveolar Ridge	( )	( )
( )	( )	Periodontal Tissues	( )	( )
( )	( )	Mobility	( )	( )
( )	( )	Caries	( )	( )

_____ Pos.	Neg.	Date	_____ Pos.	Neg.
( )	( )	Lymphatics	( )	( )
( )	( )	Lips	( )	( )
( )	( )	TMJ	( )	( )
( )	( )	Buccal Mucosa	( )	( )
( )	( )	Tongue	( )	( )
( )	( )	Floor of Mouth	( )	( )
( )	( )	Hard Palate	( )	( )
( )	( )	Soft Palate	( )	( )
( )	( )	Alveolar Ridge	( )	( )
( )	( )	Periodontal Tissues	( )	( )
( )	( )	Mobility	( )	( )
( )	( )	Caries	( )	( )

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