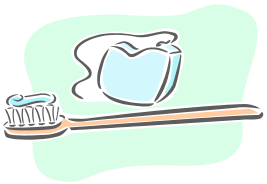


Yasaman S. Roland D.D.S.

Annapolis, Maryland 21401

410-266-3595

We would like to get

to know you better!

DATE_____

NAME_____

_____

SOCIAL SECURITY

NUMBER_____

RESIDENCE_____

_____

_____

PHONE_____

EMAIL_____

_____

( ) Minor ( ) Single ( ) married ( ) Divorced ( ) widowed ( ) Separated

Occupation_____

_____

Employer_____

_____

Address_____

_____

_____Phone_____

_____

Date of birth_____

_____

Spouse's name_____

_____

Spouse's occupation_____

Employer_____

_____

Address_____

_____

_____Phone_____

_____

Name of emergency

contact?_____

Phone_____

Name of person responsible for this account?

_____ Relationship to

patient?_____

Whom may we thank for referring you?

_____

Do you have dental insurance? _____

If yes name of dental

plan_____

_____

Address of dental insurance?

_____

_____

_____

_____

Group # of insurance plan_____

DENTAL HISTORY

(Please fill in the following)

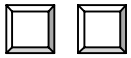
Are your teeth sensitive to?

- Heat
- Cold

- Sweets
- Biting Pressure

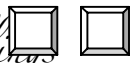
| | YES | NO |
|---|---|---|
| Does food constantly get stuck between certain teeth in your mouth? | ☐ | ☐ |
| Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? | ☐ | ☐ |
| Are you dissatisfied with your teeth In any way? | ☐ | ☐ |
| Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. | ☐ | ☐ |

Do you have any fillings that show in your front teeth?



Do any of your fillings show when you smile?

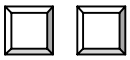
If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth- colored restoration instead?



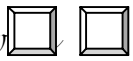
Have you ever had any teeth removed?

How long have these teeth been missing?_____

| | YES | NO |
|---|---|---|
| Do your gums bleed when brushing? | ☐ | ☐ |
| Do you ever avoid any part of the mouth while brushing? | ☐ | ☐ |
| Have you been instructed regarding proper oral hygiene? | ☐ | ☐ |
| Do you have an unpleasant taste or odor in your mouth? | | |

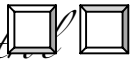


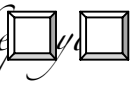
Do you smoke?

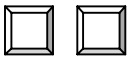
Do you frequently snack betw 
Meals or sweets or chew gum?

How often do you brush your
teeth?_____

How often do you use
floss?_____

Do you want to learn to cont 
dental disease and retain your teeth?

Has the fear of discomfort ke 
from regular visits?



Are you deeply concerned about the finances required to return your mouth to excellent dental health?

When was your last dental appointment?_____

How long has it been since you have had a full series of x-rays?_____

What prompted you to seek dental care at this time?

_____

REMARKS

MEDICAL

HISTORY

YES

NO

Do you have any general heal☐ ☐

problems?

*If so, please specify*_____

_____

*Are you currently under a physician's care?* ☐ ☐

*Reason*_____

_____

*Name and Address of Physician*

_____

_____

_

*Are you currently taking any drugs or medication?* ☐ ☐

If so, list all medications you are currently taking_____

_____

_____

_____

_____

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

Heart Ailment ____

Diabetes ____

Rheumatic Fever ____

High Blood Pressure ____

Respiratory Disease ____

Hepatitis ____

Prolonged Bleeding ____

Healing Complication ____

*Do you have any allergies to medications if so, what medications?*_____

_____

*Would you like your blood pressure checked while you are here?*_____

_____

*Why did you leave your last dentist?*

_____

_____

*SIGNATURE*_____

_____