Yasaman S. Roland D.D.S.
Annapolis, Maryland 410-266-3595

We would like to get to know you better!

DATE_____
NAME_____
RESIDENCE_____
_____ PHONE_____
OCCUPATION_____
EMPLOYER_____
ADDRESS_____
_____PHONE_____
DATE OF BIRTH_____
MARITAL STATUS_____
SPOUSE'S NAME_____
SPOUSE'S OCCUPATION_____
EMPLOYER_____
ADDRESS_____
_____PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU?

Person financially responsible for this account

Do you have a dental benefit plan?_____
If yes, carrier_____

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,	☐	☐
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?_____

Do your gums bleed when brushing?	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐
	☐	☐

Have you been instructed regarding proper home care?

Do you have an unpleasant taste or odor in your mouth? ☐ ☐

Do you smoke? ☐ ☐

Do you frequently snack between Meals on sweets or chew gum? ☐ ☐

How often do you brush your teeth?_____

How often do you use floss?_____

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

Has the fear of discomfort kept you 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?_____

What did you have done?_____

How long since your last thorough examination with full mouth x-rays?_____

What prompted you to seek dental care at this time?

REMARKS

MEDICAL HISTORY

YES NO

Do you have any general health 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, what?_____

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

Heart Ailment	___	___
Diabetes	___	___
Rheumatic Fever	___	___
Epilepsy	___	___
High Blood Pressure	___	___
Respiratory Disease	___	___
Hepatitis	___	___
Prolonged Bleeding	___	___
Healing Complication	___	___
Allergy to any Drugs	___	___

Would you like us to take your blood pressure? _____

Why did you leave your last dentist?

_____

SIGNATURE_____