

Welcome to Main Line Dental Aesthetics

12 S. Valley Road Paoli, PA 19301

www.PaoliDentist.com

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions.

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

How did you find out about our office? Personal Referral (name) _____ Postcard _____

TV _____ Internet _____ (if you found us on the internet what key words did you use?) _____

Magazines (which one) _____ Newspaper (which one) _____ Other _____

Are you having any areas of concern? _____

Tell us in your opinion what you think the present state of your mouth is:

How healthy do you want us to get your mouth Don't really care _____ Average _____ The best it can be _____

Tell us about your good dental experiences: _____

And the bad ones: _____

What caused you to leave your last dental office? _____

How do you feel about the appearance of your smile? _____

What would it take for you to trust us to be your dentist? _____

Do you have any family or friends that already come to our office? _____

What do you already know about our office and what are your expectations? _____

Has fear ever been an issue for you in a dental office? _____

Has time ever been a factor in getting your dental work done? _____

Has the cost of dental treatment been a concern for you? _____

What can we do to help you with this? _____

We have the unique ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (Please circle)

As a **general** dentist

As a **cosmetic** dentist

As a **functional** dentist

Should you need treatment, at what point should we address it? (Please circle)

When my tooth hurts or breaks

When something is worsening

When something isn't ideal

What quality of dentistry do you want us to recommend? (Please circle)

Just patch it

Average

Ideal/the best

Is there any additional information that you would like us to know?

Health and Dental History

Physician's Name _____ Phone # _____

Are you taking any medication now, including regular dosages of Aspirin, Tylenol, Motrin, Vitamins? Yes No

If so, please list _____

Are you aware of having an allergic reaction to any medication or substance? Yes No

If so, please list _____

Have you been under the care of a medical doctor during the past two years? Yes No

If so, for what? _____

Have you seen an ENT (ear, nose and throat doctor)? Yes No Name _____

Have you been diagnosed with Sleep Apnea? Yes No If yes, when? _____

Have you seen a chiropractor? Yes No Name _____

Have you seen a neurologist? Yes No Name _____

Have you had braces? Yes No Name _____

Indicate which of the following you have had, or have at present. Check “yes” or “no” to each item.

Condition	Yes	No	Condition	Yes	No
Heart Concerns			Headaches		
Congenital Heart Disease			Jaw Pain		
Heart Murmur			Jaw Popping		
High or Low Blood Pressure			Limited Opening		
Mitral Valve Prolapse			Congested Ears		
Artificial Heart Valve			Dizziness		
Pacemaker			Ringling Ears		
Stroke			Loose Teeth		
Do you smoke or chew tobacco?			Posture Problems		
Asthma			Clenching		
Liver disease/jaundice			Do your gums bleed?		
Latex Sensitivity			Grinding		
Artificial Joints			Does your breath concern you?		
Kidney Trouble			Facial Pain		
Radiation/Chemotherapy			Sensitive Teeth		
Epilepsy/seizures			Neck Ache		
Diabetes			Bell's Palsy		
Hepatitis			Difficulty Swallowing		
Have you been tested for HIV Virus?			Difficulty Chewing		
Sickle Cell Disease			Trigeminal Neuralgia		
Neurological Disorders			Tingling in arms/fingers		
Does floss shred when you use it?			Insomnia/frequent waking		
Thyroid Problems?			Sinus Or Allergy Problems?		

Is there a family history of cancer? Yes No If yes, who? _____

Do you have or have you had any disease, condition or problem not listed? _____

Do you play any sports and or work out? Yes No If yes, what sport and how often? _____

Women: Are you: Pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health, and necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication. I understand that I am responsible for all services rendered on my behalf and/or my dependents.

Signature _____ Date _____

Social Security Number _____ Date of Birth _____

Email Address _____

Cell Phone number _____ Marital Status ___S___M___D___W

Place of Employment: _____

Address _____ Phone _____

Dental Insurance _____ Phone number _____

Address _____

Group # _____ ID# _____

Subscriber's Name _____ SS# _____ DOB _____

Subscribers Employer _____

Address _____ Phone _____

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