Paul A. Romano, DDS, PC

This questionnaire provides us with relevant information concerning your health. ANY MEDICATIONS USED FOR MEDICINAL OR RECREATIONAL PURPOSES MUST BE REPORTED ON THIS FORM. Answer all questions. Use permanent ink.

Answers to the questions are for our records only and will be considered confidential.

Today's Date_____ Birthdate _____

Patient's Name_____Social Security #_____

If patient is a minor, give parent's or guardian's name _____

Home Address_____City_____State_____Zip_____

Home Phone _____Work Phone _____Cell Phone _____

E-Mail_____Spouse's Name_____

Medical Doctor _____Dr's Phone_____

Employer_____Employer Address_____

Whom may we thank for referring you to our office?_____

Primary Dental Insurance Information	**Secondary Dental Insurance Information**
Subscriber Name_____	Subscriber Name_____
Birthdate_____ Relationship to Patient_____	Birthdate_____ Relationship to Patient_____
Employer Name_____	Employer Name_____
Employer Address_____	Employer Address_____
Group#_____Insured's ID#_____	Group#_____Insured's ID#_____
SS#_____	SS#_____
Insurance Co. Name_____	Insurance Co. Name_____
Address_____	Address_____
City_____State_____Zip_____	City_____State_____Zip_____
Phone #_____	Phone #_____

Dental History

When did you have your last cleaning?			Have you ever had periodontal (gum) surgery?	Y	N
When did you last have X-Rays?			Is your mouth dry?	Y	N
When was your last dental exam?			Do you smoke?	Y	N
Have you had a toothache recently?	Y	N	Do you chew tobacco?	Y	N
Do your gums ever bleed?	Y	N	Would you like your teeth lightened?	Y	N
Do you ever have a bad taste in your mouth?	Y	N	Is there anything you do not like about the appearance of your teeth?	Y	N
Do you have bad breath?	Y	N	If yes, Please explain:		
Do you have difficulty chewing food?	Y	N			
Do you have sensitive teeth?	Y	N			
Does your jaw pop or click?	Y	N			
Have you ever had an injury to your face or jaw?	Y	N			
Do you have difficulty swallowing?	Y	N			