**ANDOVER DENTRISTY LLC**
**MARLAYNA C BEST, DMD, LLC**

## ADULT EXAMINATION QUESTIONNAIRE

Name_____Date_____

Address_____Home Phone(  )_____

Town, State and Zip Code_____

E-Mail _____Fax_____Cell_____

Employer_____Present Position_____

Business Address_____Work Phone(  )_____

Town, State and Zip Code_____

Date of Birth_____Marital Status_____

Do you have dental insurance?_____Insurance Company_____

Group #_____Social Security #_____

In order to aid us in evaluating your dental health thoroughly and completely; please complete the following examination questionnaire. This will become part of your office record and will be held in strict confidence.

1. What prompted you to seek dental care at this time?_____
2. How long since your last thorough dental exam?_____
3. Were x-rays of all teeth taken at that time?_____
4. Were your teeth cleaned?_____
5. Has the fear of discomfort kept you from regular dental visits?_____
6. Are you troubled with bad breath?_____
7. Do your gums bleed easily, feel tender or irritated?_____
8. Are you self-conscious about the appearance of your teeth?_____
9. Would you like to retain your healthy natural teeth as long as possible?_____
10. Are you aware of grinding or clenching your teeth?_____
11. Have you lost any teeth other than wisdom teeth?_____
12. Have they been replaced?_____
13. Have you noticed any loose, shifted or tipped teeth?_____
14. Have you had the nerves of any teeth removed?_____
15. Have you noticed any tooth darkening due to black tarnishing silver restorations?___
16. In the past have you had the opportunity to choose your dental treatment?_____
    If so what was your choice? Porcelain_____Plastic____Silver_____Gold_____

17. Would you prefer a local anesthetic for most dental treatment?_____
18. Are you satisfied with your past dentistry?_____

19. Whom may we thank for this referral?_____
20. How long since you last complete medical exam?_____
21. Are you under the care of a physician now?_____
    For what reason?_____
    Name of your physician_____
    Name of previous dentist_____
    May we request your previous dental records to facilitate proper treatment in our Office?_____
22. Are you receiving any medication?_____
    What?_____
23. Do you have any allergies?_____
    What?_____
24. Have you ever had any of the following?
    Radiation Therapy_____
    Diabetes_____
    Arthritis_____
    Rheumatic Fever_____
    High or Low Blood Pressure_____
    Heart Condition_____
    Hip or Knee replacement_____
    Hepatitis_____
    Suppressed Immune system_____
    Chemotherapy_____
    HIV Positive_____
    Any other conditions_____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I have read and answered all the above questions and to the best of my knowledge the information is true and complete. I understand that payment for treatment is expected at the time of service unless other arrangements are made. I further understand that a finance charge of 1.5% per month may be placed on my account if it becomes 30 days past due. If my account has to be put in collections, I will pay any legal fees that may be incurred.

Patients Signature_____

Doctors Signature_____
We gladly accept Visa, Mastercard, American Express and Discover.