



LYNNE D. MARTZ, D.D.S.

ANDREW D. MARSHALL, D.D.S.

AESTHETIC NEUROMUSCULAR & FUNCTIONAL DENTISTRY

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WE'D LIKE TO GET TO KNOW YOU

Welcome to the office of Dr. Lynne Martz and Dr. Andrew Marshall. We appreciate your time completing this questionnaire and look forward to your visit.

Name: Dr Mr. Mrs. Ms

First Name

Last Name

Address

City

State

Zip

Home: ()

Work: ()

Cell: ()

Date of birth: E-Mail:

Employer's Name

()

Phone

Address, including suite #

City

State

Zip

Are you happy with your smile? _____

Is anything in your mouth bothering you or causing you discomfort right now? Yes No

Are your teeth sensitive to hot, cold, sweets, or biting pressure? _____

How often do you brush? 1 x day 2 x day More

Do you use a manual or electric toothbrush? _____

Do you floss? Yes No

Do your gums bleed when you brush or floss? UL LL UR LR

Do you have any teeth where food gets stuck or floss shreds? UL LL UR LR

Would you like to have whiter teeth? Yes No

If you have used whitening products or methods in the past, please tell us what you have tried.

Are you concerned with the way your breath smells? Yes No

Please provide the name and contact information for your former dentist.

Name () Phone

Address City State Zip

Important Dates

Date of last Professional Cleaning _____

Date of last Bitewing Digital Images* _____

Date of last Full Mouth Digital Images* _____

* Please contact your previous dentist to authorize release of all digital images or x-rays and request that a copy be forwarded to our office prior to your first visit.

Has your previous dentist advised you of any areas of concern? Yes No

If so, please explain. _____

How often do you have your teeth cleaned each year? _____

Have you ever had any of the following?

Periodontal (Gum) Treatment Yes No

Root Canal Therapy Yes No

Orthodontics (Braces) Yes No

Oral Surgery Yes No

Have you ever had pain in your jaw joint (TMJ)? Yes No

Do you clench or grind your teeth? Yes No

Do you have headaches or ringing in your ears? Yes No

Have you ever worn a night guard? Yes No

Are you now under a physicians' care? If so, please tell us for what condition.

Please tell us if you are taking drugs, medications, vitamins at this time.

Name		Reason
1.		
2.		
3.		
4.		
5.		

Have you ever been told to take antibiotics before dental treatments or teeth cleaning? Yes No

Do you smoke tobacco products? Yes No If so, how much? _____

Have you ever had an unusual reaction to any of the following? If you answer yes to any of the below, please give us more information (e.g. which antibiotics you are allergic to and what reaction you've had).

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<u>Name of Substance</u>	<u>Reaction</u>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Aspirin, Advil or other anti-inflammatory medicines	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Base metals, e.g. nickel, lead	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Codeine or other pain medicines	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dental Anesthetics "Numbing"	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dental Materials	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Latex	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Have you ever been tested for biocompatibility with dental materials? If so, please provide details: (e.g. Clifford Reactivity Test, Sept 2002, no sensitivities) _____

Have you received treatment for drug or alcohol abuse? Yes No

Have you ever taken Redux or Phen-Phen? Yes No

For Women Only:

Are you pregnant? Yes No Are you nursing? Yes No

Do you take birth control pills? Yes No

Have you ever had any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal bleeding (Prolonged) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemakers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial implants/valves | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis – A, B or C | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Dizziness/fainting spells | <input type="checkbox"/> HIV+ /AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | |
| <input type="checkbox"/> Blood Transfusion | Date: _____ | Location: _____ |

Please tell us whom we may thank for referring you to our office or how you heard about us:

CONSENT

I understand that the information provided here is complete and true to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my health status. I authorize Dr. Andrew Marshall and Dr. Lynne Martz and staff to perform any and all necessary dental diagnoses and treatment, with my informed consent.

Client Signature Date

If the client is a minor, a parent or legal guardian must sign.

Parent or Legal Guardian Relationship to Client Date

Warmest regards,

Dr. Lynne Martz
Dr. Andrew Marshall

THANK YOU!!!