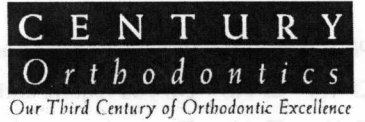


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ADULT PATIENT INFORMATION

TODAY'S DATE ____/____/____

* Please complete and return by mail if you have the time. If not please bring completed form to the office. It will save you time at the office.

Mr. Mrs. Miss Ms. Dr. _____

Birth date _____ Age _____ Social Security # _____ E-mail Address _____

Home Address _____

City _____ State _____ Zip _____ Home Phone # _____

Would you object to an automated telephone call to remind you of an upcoming appointment? Yes No

Employer _____ Address _____

City _____ State _____ Zip _____ Business Phone # _____

Occupation _____ Insurance _____

Married Separated Single

Spouse's name _____ Social Security # _____

Employer _____ Address _____

City _____ State _____ Zip _____ Business Phone # _____

Occupation _____ Dental insurance _____

Person & address responsible for account (credit bureau reports, where appropriate, may be obtained) _____

Physician _____ Date of last complete examination _____

Dentist _____ Since _____ Date of last dental examination _____

Other Dentist(s) _____ Specialty(s) _____

Have you completed all recommended dental work? Yes No Do you see your dentist on a regular basis? Yes No

How did you come to choose our office (indicate as many as applicable)

dentist referral insurance plan referral location _____

other family members treated at this office: Names _____

recommendations of neighbors and friends: Names _____

other (physician, Yellow Pages, dental society, etc.) _____

Have you recently had an orthodontic evaluation or orthodontic diagnostic records taken? Yes No

Have you ever had previous orthodontic treatment or worn a "retainer" or "biteplate"? _____

When? _____ By? (Dentist, Orthodontist) _____

Have you been treated for periodontal (gum) disease? _____

When? _____ By? (Dentist, Periodontist) _____

What is your primary concern (why are you here?) _____

Please complete other side

Please check YES or NO. If Yes, please fill in details.

- Yes No Do you require antibiotic premedication for dental work? _____
- Yes No Do you have a current medical problem? What? _____
- Yes No Do you have heart trouble? Congenital heart lesions? Had rheumatic fever? _____
- Yes No Do you have high or low blood pressure? Is it controlled? _____
- Yes No Have you ever had diabetes? How is it controlled? _____
- Yes No Are you subject to fainting or dizziness? When? _____
- Yes No Do you have epilepsy? Medication? _____
- Yes No Do you have headaches? How often? _____
- Yes No Psychological or nervous disorders? How is it controlled? _____
- Yes No Are you allergic to any medication? Metals? Latex? etc.? _____
- Yes No Endocrine (gland) or blood disorders? kidney disease? anemia? _____
- Yes No Do you have asthma? hay fever? severe allergies? _____
- Yes No Have you ever had infectious hepatitis? jaundice? tuberculosis? _____
- Yes No Have you ever had any major operations? cancer or tumors? _____
- Yes No Radiation treatment to head area? _____
- Yes No Are you taking any medication? Please list: _____
- Yes No Do you use tobacco? How much? _____
- Yes No Have you ever had any sexually transmitted diseases? _____
- Yes No Are you H.I.V. positive? _____
- Yes No Do you perspire excessively at night? Have persistent diarrhea? Have a purplish rash or persistent bruise(s)? _____
- Yes No Have you had prolonged coughing or coughed up blood? _____
- Yes No Have you lost weight recently without dieting? How much? _____

- Yes No Do you have any growth, swellings, or sores in your mouth? _____
How long have they existed? _____
- Yes No Is any part of your mouth sensitive to temperature, pressure, food, or drink? _____
- Yes No Do you ever have any pain or soreness around your eyes, ears, or other parts of your face? _____
- Yes No Bleeding or swollen gums? _____
- Yes No Are you aware of stiff neck muscles? How often? _____
- Yes No Do you ever awaken with awareness of your teeth or jaws? How often? _____
- Yes No Are you aware of clenching your teeth during the daytime? _____
- Yes No Have you ever been told you grind your teeth during sleep? _____
- Yes No Are you aware of your jaw clicking or popping while eating or yawning? _____
- Yes No Do you have difficulty in opening your mouth widely? _____
- Yes No Have your jaws ever locked open or closed? _____

For Women

- Yes No Are you pregnant? Expected delivery date? _____
- Yes No Are you on any hormonal therapy or being treated for potential osteoporosis? _____

Please amplify answers on a separate sheet of paper if necessary.

SIGNATURE _____ DATE _____