PATIENT INFORMATION

****Please Print** Date_____

Patients Legal Name_____Preferred Name_____M_____F_____

Home Address_____ City/State/Zip_____

Mailing Address_____ City/State/Zip_____

Home Ph# _____ Work Ph# _____ Cell #_____ email _____

SSN _____ DL#/State _____ Date of Birth _____ Marital Status S M D W

Your Occupation_____ Employer_____Bus Tel#_____

Spouse's Name_____ SSN _____ Date of Birth _____

Spouse's Occupation_____ Employer_____Bus Tel#_____

Person to contact in an emergency_____ Relationship_____

Res Tel#_____ Bus Tel #_____ Cell #_____ Address _____

Person responsible for account_____ Res Tel#_____ Bus Tel #_____

What is your chief complaint or concern?_____

***Whom May We Thank for Referring You?*_____**_____

DENTAL INSURANCE INFORMATION

Primary:

Insured_____ SSN:_____ ID#_____DOB_____

Ins Co _____ Ph #_____ Group #_____

Secondary:

Insured_____ SSN:_____ ID#_____DOB_____

Ins Co _____ Ph #_____ Group #_____

DENTAL HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL.

Previous Dentist_____ City_____ How Long_____

Date of last visit_____Last cleaning_____Last full series of xrays_____

1. Why did you leave your last dentist?_____
2. What did you like about any dentist or dental office you have been to?_____
3. What did you like the least?_____
4. Are you having any discomfort at this time? No_____ Yes_____, _____
5. Have you ever had any serious trouble associated with previous dental treatment? Yes_____ No_____
   If so, please explain_____
6. Does dental treatment make you nervous? Yes_____ No_____
7. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes_____ No_____

Check any of the following you have had or currently have:

_____ Gum Abscesses
_____ Gums bleed when brushing
_____ Grind or clench your teeth
_____ Pain, Clicking, Popping in jaw joints
_____ Orthodontic treatment (braces)
_____ Immediate relative that has lost all their natural teeth
_____ Mouth odor or bad taste
_____ Cold sores or fever blisters
_____ Loose or shifting teeth
_____ Sensitive teeth (hot, cold, sweets)
_____ Awake with sore jaws
_____Missing teeth

Prosthetics:

_____Ill Fitting
_____Painful
_____Trouble eating
_____Appearance

What is the one thing you would like to change about your smile?_____

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