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

_____ 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

If you could change one thing about your smile, what would thatbe?____

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