PATIENT INFORMATION

Date: _____

First Name:_____ MI:____ Last:_____ Preferred:_____

Birth Date:_____ Age:_____ SS#:_____ Sex: M F

Cell Phone:_____ Work Phone:_____EXT_____ Home Phone:_____

Which is the best Number/Time to reach you? _____ Text/Email reminders?_____

Address:_____City:_____ State:_____ Zip:_____

Email:_____ □ Married/Partnered □ Widowed □ Single □ Minor

Emergency Contact:_____ Relationship:_____Phone:_____

Who may we thank for referring you?_____

DENTAL INSURANCE INFORMATION

PRIMARY

Insurance Company_____

Customer Service Phone Number_____

Employer_____

Group Name_____Group Number_____

Subscriber_____ DOB_____

Subscriber/Member ID/SSN_____

Relationship to Patient _____

SECONDARY

Insurance Company_____

Customer Service Phone Number_____

Employer_____

Group Name_____Group Number_____

Subscriber_____ DOB_____

Subscriber/Member ID/SSN_____

Relationship to Patient _____

DENTAL HISTORY

Date of last dental visit: _____

Name of your previous dentist: _____

Reason for your visit today: _____

Have you ever had an oral cancer screening? Y N

How often do you brush? _____

How often do you floss? _____

Have you/family member ever been treated for periodontal disease? Y N

Have you ever had complications from an extraction? Y N

Have you ever had popping/clicking near your ear when you chew? Y N

Are you prone to frequent headaches? Y N

Do you grind/clench your teeth? Y N

Do you have □ Sores □ Blisters □ Loose/Broken fillings

□ Dry Mouth □ Food Collection □ Bleeding Gums

□ Mouth Breathing □ Nail Biting □ Chew on one side

Swollen/Tender □ Gums □ Lips □ Cheeks

Have you ever had Orthodontic treatment? Y N

Do you snore? Y N

Do you have problems with bad breath? Y N

Have you ever had an allergic reaction to:

□ crown

□ metal filling

□ dental appliance

Have you ever used an Power Toothbrush? Y N

Waterpik? Y N

Are your teeth sensitive to □ Hot □ Pressure

□ Cold □ Sweets

On a scale of 1-10 (10 highest), Please indicate how important your dental health is to you.

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, what would it be?

□ Whiter

□ Close space

□ Replace dark fillings with tooth colored restorations

□ Repair Chipped teeth

□ Replace Missing teeth

□ Replace old crowns that don't match