



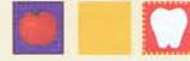
# WELCOME



We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.



## PATIENT INFORMATION



Date \_\_\_\_\_

Occupation \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Patient Name \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_

Spouse's Name \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

E-mail \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years



## DENTAL INSURANCE



Subscriber's Name \_\_\_\_\_

Is patient covered by secondary insurance?  Yes  No

Relationship to Patient \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Group # \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_



## PHONE NUMBERS



Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_



## DENTAL HISTORY



Reason for today's visit \_\_\_\_\_

Please check () "yes" or "no" to indicate if you have had any of the following:

\_\_\_\_\_

Bad breath  Yes  No Jaw pain or tiredness  Yes  No

Former Dentist \_\_\_\_\_

Bleeding gums  Yes  No Lip or cheek biting  Yes  No

City/State \_\_\_\_\_

Blisters on lips or mouth  Yes  No Loose teeth or broken fillings  Yes  No

Date of last dental visit \_\_\_\_\_

Burning sensation on tongue  Yes  No Mouth breathing  Yes  No

Date of last dental X-rays \_\_\_\_\_

Chew on one side of mouth  Yes  No Mouth pain  Yes  No

How often do you floss? \_\_\_\_\_

Cigarette, pipe, or cigar smoking  Yes  No Orthodontic treatment  Yes  No

How often do you brush? \_\_\_\_\_

Clicking or popping jaw  Yes  No Pain around ear  Yes  No

Do you wear contact lenses?  Yes  No

Dry mouth  Yes  No Periodontal treatment  Yes  No

Fingernail biting  Yes  No Sensitivity to cold  Yes  No

Food collection between the teeth  Yes  No Sensitivity to heat  Yes  No

Foreign objects in mouth  Yes  No Sensitivity to sweets  Yes  No

Grinding teeth  Yes  No Sensitivity when biting  Yes  No

Gums swollen or tender  Yes  No Sores or growths in mouth  Yes  No