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 _____

SS/HIC/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

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 _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss? _____

How often do you brush? _____

Do you wear contact lenses? ☐ Yes ☐ No

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	
Bleeding gums	☐ Yes ☐ No		Lip or cheek biting	☐ Yes ☐ No	
Blisters on lips or mouth	☐ Yes ☐ No		Loose teeth or broken fillings	☐ Yes ☐ No	
Burning sensation on tongue	☐ Yes ☐ No		Mouth breathing	☐ Yes ☐ No	
Chew on one side of mouth	☐ Yes ☐ No		Mouth pain	☐ Yes ☐ No	
Cigarette, pipe, or cigar smoking	☐ Yes ☐ No		Orthodontic treatment	☐ Yes ☐ No	
Clicking or popping jaw	☐ Yes ☐ No		Pain around ear	☐ 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	