Patient Information

Patient's Name: ____Today's Date: ____________
Home Address ____
City____________________________ Zip_________ Res. Tel.#_______________ Cell# ______________________
Social Security # _____-_____-_____ Date of Birth _____/_____/_____ Age____________ Marital Status S/M/D/W
Your Occupation______________________ Employer________________________ Bus.Tel# __________________
Spouse's Name____ Social Security # _____-_____-_____
Your spouse's Occupation_____________________ Employer_________________________ Bus.Tel# ______________
Person to contact in an emergency____ Relation____________________
Res. Tel. #__________________ Bus. Tel. #________________ Address_______________________________________
Party responsible for account ___________________________ Bus Tel. #________________ Res Tel.#________________
Email address: __________________________
Reason for this visit ____
Whom may we thank for referring you?____

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

Dental History:

Previous Dentist_______________________________ City_______________________ How long___________________
Date of last visit______________ Date of last dental cleaning___________ Date of last full mouth x-ray _____________
1. What did you like most about any dentist, or a dental office you have been to?__________________________________
2. What did you like least about any dentist, or dental office that you have been to?_______________________________

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

___ Orthodontic Treatment
___ Have Lightened Your Teeth Before
___ Grind or Clench your teeth (Daytime or Nighttime)
___ Pain, Clicking, Popping in Jaw Joints
___ Awake with Sore Jaws
___ Periodontal Treatment
___ Gum Abscesses
___ Loose, Shifting or missing Teeth
___ Trouble Chewing/Speaking
___ Fear of Dental Treatment
___ Sensitive Teeth (Hot, Cold, Sweets)
___ Bridges, Partials or Dentures
___ Gums Bleed when Brushing
___ Mouth Odor or Bad Taste

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

____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? Y N

Do you want to keep your teeth? ____ Yes, no matter how much trouble ____ I don't know
____ Yes, if it's not too much trouble ____ I don't care