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