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Date ________________________

Welcome to our office. Please answer all questions. This information is confidential and will help us serve you better. If at any time you have any questions regarding your treatment, your appointments, or fees, please ask.

Name ____ Date of Birth __________________

Name You Wish To Be Called __________________________________ Marital Status _________________

Address ____________________________City ____________________ State _______ Zip Code _______

Home Phone __________________ Cell Phone ____________________ Email _______________________

Social Sec. # ________________________ Student __________ School ____________________________

Employer _________________________________ Address _______________________________________

Occupation _______________________________ Work Phone __________________ Ext. _____________

Name of Spouse ___________________________ Employer ______________________________________

Person Responsible for Payment ____

Address ____

Family Physician _______________________________________ Date of Last Medical Exam _____________

Emergency Contact 1: Name _____________________________ Phone ____________________________

Emergency Contact 2: Name _____________________________ Phone ____________________________

Who Referred You to This Office ____

PLEASE INDICATE BELOW HOW YOU PREFER TO PAY FOR YOUR DENTAL TREATMENT

Cash _______ Personal Check ______ Dental Insurance ______ Credit Card _______

Insured Name _____________________________ Insured Date of Birth _____________________________

Insured Soc. Sec. # _________________________ Policy Number __________________________________

Employer Providing Insurance ____

Insurance Company Name ____

Other Insurance? (if yes)____

Insured Name _________________________________ Insured Date of Birth ________________________

Insured Soc. Sec. # ____________________________ Policy # __________________________________

Employer Providing Insurance ____________________Insurance Company Name _________________

Continued on the other side. Turnover please →

DENTAL HISTORY

What is the purpose of your visit today? ____

	YES	NO
Is your mouth comfortable?	☐	☐
Do you receive regular dental care?	☐	☐
Are you pleased with the health of your teeth?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐

If not, what would you change? ____

Would you like your teeth whitened?	☐	☐
Do you chew on both sides of your mouth?	☐	☐

Are your teeth sensitive to: (circle all that apply) **cold** **sweets** **hot** **biting pressure**?

Do you experience frequent headaches?	☐	☐
Do you have dental anxiety?	☐	☐

If yes, what is the cause? ____

Have you had a complete set of mouth x-rays?	☐	☐

If yes, when? __________________________ If yes, what office? ____________________________________

Do you have any sores or swelling in your mouth?	☐	☐
Do you have difficulty opening or closing?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you wear a mouth guard/night guard?	☐	☐
Have you worn braces?	☐	☐
Do your gums bleed when brushing or flossing?	☐	☐
Have you been told you have periodontal disease?	☐	☐
Do you ever experience dry mouth?	☐	☐

What is the date of your last dental exam or visit? _________________________ Where? ___________________

What was the date of your last dental cleaning? ___________________________

How often do you: Brush _______ Floss _______ Proxabrush _______ Rinse _______

I, _________________________, have received a copy of this office's Notice of Privacy Practices.

Pint Name_______________________________________

Signature _______________________________________

Date____