Patient Information

Patient's Name _____ Today's Date _____

Home Address _____

City_____ Zip_____ Res. Tel.#_____

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. Why did you leave your last dentist?_____
2. What did you like most about any dentist, or a dental office you have been to?_____
3. 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
___ Gums Bleed when Brushing
___ Mouth Odor or Bad Taste
___ Bruise Easily
___ Loose, Shifting or missing Teeth
___ Trouble Chewing/Speaking
___ Fear of Dental Treatment
___ Immediate Relatives that have lost all of their Natural Teeth
___ Complications with or following previous Dental or Oral Surgical treatment
___ Sensitive Teeth (Hot, Cold, Sweets)
___ Cold Sores or Fever Blisters
___ Bridges, Partials or Dentures

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