

## PATIENT INFORMATION

**Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.**

Patient name: \_\_\_\_\_ How may we address you: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: \_\_\_ Age: \_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing address: (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Drivers license #: \_\_\_\_\_ State: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Spouse's name & phone #: \_\_\_\_\_ Emergency phone # (other an spouse): \_\_\_\_\_

Primary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Social security #: \_\_\_\_\_

Name of your physician: \_\_\_\_\_ Date of last visit to physician: \_\_\_\_\_

Name of previous dentist: \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_

### Dental Health History

	Yes	No		Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw click or pop?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Have your experienced any pain or soreness in the muscle of your face around your ear?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any unpleasent dental experiences or is there anything about dentistry that you dislike?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain _____		
Are any of your teeth loose ,tipped, shifted or chipped?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever had gum treatment or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had permanent teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>
Are any of your teeth sensstive to:			Do you use dental floss	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hot			How often do you brush? _____		
<input type="checkbox"/> Cold					
<input type="checkbox"/> Sweets					
<input type="checkbox"/> Pressure					

### CONSENT

I consent to the diagnostic procedeures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use of my records (or my child's record) to carry out treatment, obtain payment, and for those activities and healthcare operations that are related to payment or treatment.

I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I attest to the accuracy of the information on this page.

\_\_\_\_\_  
PATIENT'S OR GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE