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 this 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: _____ Preferred name: _____ DOB: _____

Sex: _____ Age: _____ Social Security: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ email: _____

Employer/occupation: _____ Business phone: _____

Spouse's name & phone #: _____ Emergency contact # (other than spouse): _____

Primary dental insurance: _____ ID #_____ Group # _____

Secondary dental insurance: _____ Subscriber's name: _____ DOB: _____

ID # _____ Group #_____ Secondary insured SS #: _____

Physician's name: _____ Date of last visit to physician: _____

Previous dentist's name:_____ Date of last visit to dentist: _____

Dental Health History

	Yes	No
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you avoid brushing any part of your mouth due to pain?	☐	☐
Are any of your teeth loose, tipped, shifted or chipped?	☐	☐
Have you ever had gum treatment or surgery?	☐	☐
Have you ever had permanent teeth removed?	☐	☐
Are your teeth sensitive?	☐	☐

If yes, are your teeth sensitive to:

☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

	Yes	No
Are you dissatisfied with the appearance of your teeth?	☐	☐
If yes, why? _____		
Do you clench or grind your teeth?	☐	☐
Does your jaw click or pop?	☐	☐
Have you experienced any pain or soreness in the muscle of your face around your ear?	☐	☐
Do you regularly use dental floss?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bled when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐

How often do you brush your teeth? _____

What is your chief concern regarding your dental health? _____

CONSENT

I consent to the diagnostic procedures 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 or guardian signature: _____ Date: _____