PATIENT INFORMATION & DENTAL HISTORY

Name: ____

Address: ____

City/State/Zip: ____________________________________

Date of Birth: ________________ Gender: Male / Female

Primary phone number: ______________________ (Home/Mobile)

Alternate number: __________________ (Home/Mobile/Work)

How would you like to be contacted for appointment reminders and routine announcements? CALL TEXT EMAIL

If by TEXT message, who is your mobile carrier: ____________

If by email: ______________________________________

DENTAL INSURANCE:

If the insured, we will need a copy of your insurance card and driver's license.

Name of insured: ______________________________

Date of birth of insured: ______________________________

Employer of insured: ______________________________

Social Security Number: __________ - _______ - __________

Why do we need your social security number? We will need your social security number when we contact your insurance company. Your personal information will never be sold to a third party or distributed outside our office.

Responsible Party (if other than patient):

Name: __________________________________

Address: __________________________________

City/State/Zip: __________________________________

Phone Number: __________________________________

Relationship: __________________________________

Emergency Contact:

Name: __________________________________

Phone Number: __________________________________

Relationship: __________________________________

What is the reason for your visit today? ____

When was your last dental exam and cleaning? ____

Are you experiencing any discomfort or pain at this time? YES NO

Are you able to drink, eat, and chew satisfactorily? YES NO

Do you get headaches? YES NO How Often? ____________________________

Do you ever hear ringing in your ears? YES NO How Often? ____________________________

Do you ever experience neck and/or shoulder pain? YES NO

Do you grind or clench your teeth? YES NO

Have you ever been in an accident that caused trauma to your head/face/neck? YES NO

Have you EVER had ANY serious trouble with ANY previous dental treatment? YES NO

If YES, please explain: ____

How would you rate your level of dental anxiety? None / Slight / Moderate / High / Need Sedation for Treatment

How would you rate the appearance of your teeth/smile on a scale of 1-10 (1 = "I hate to smile" 10 = "My smile is perfect")

1 2 3 4 5 6 7 8 9 10

Do you have any other dental concerns you would like to have addressed? YES NO

If YES, please explain: ____

Patient (Guardian) Signature: Date: