PATIENT INFORMATION

DATE_____

Name _____ ☐ Married ☐ Single ☐ Child ☐ Other
Last First Middle Nickname
Birthday / /
Address _____ Apt #_____ Driver's License # _____ State___
City _____State_____ Zip code _____ Social Security # _____
Home Phone( ) _____Work Phone( ) _____Ext___
Cell phone( )_____Pager( )_____ E-mail_____

Employer _____ **In case of an emergency, please contact**:
Occupation _____ Name_____ Relationship_____
Business Address _____ Phone_____ Cell phone_____
City _____State _____Zip code _____ Nearest relative not living with you_____
Relationship to patient_____Phone_____

Whom may we thank for referring you? _____
Is another member of your family a patient at our office? ☐ Yes ☐ No Their name? _____

Method of payment: ☐ Cash ☐ Check ☐ VISA/MC/Discover

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT ☐ Patient ☐ Parent ☐ Guardian

Name _____ Social Security # _____
Last First Middle Nickname Driver's License # _____ State_____
Birthday / /
Address _____Apt #_____
City _____State_____ Zip code _____ Employer _____
Home Phone ( ) _____Work Phone( ) _____Ext____ Occupation _____
Cell phone/pager_____ E-mail_____ Business Address _____
How long at present address? _____ City _____State _____Zip_____

DENTAL HISTORY

1. Are you presently in pain? ☐ YES ☐ NO
   ☐ Teeth ☐ Jaw ☐ Gums ☐ Face ☐ Other
2. Have you had any teeth removed? ☐ YES ☐ NO
   If the teeth were replaced, how? _____
3. Is any part of your mouth sensitive to the following? ☐ YES ☐ NO
   ☐ Hot ☐ Cold ☐ Pressure ☐ Sweet ☐ Sour ☐ Other
4. Have you ever had periodontal treatment or gum surgery? ☐ YES ☐ NO
   If YES, when? _____By whom?_____
5. Please check known conditions:
   ☐ Bleeding gums when brushing ☐ A burning sensation in your mouth ☐ Grind/clench at night
   ☐ Food catches between your teeth ☐ Bad taste or odor in your mouth ☐ Jaw clicking or popping
   ☐ Feel anxious about dental treatment ☐ Unusual dryness in your mouth ☐ Tired, stiff, or painful jaw muscles
6. Are you aware of any growths or swellings in your mouth? ☐ YES ☐ NO
   If YES, where are they located and how long have they existed? _____
7. Are you dissatisfied with the appearance of your teeth? ☐ YES ☐ NO
   If YES, what would you most like to change? _____
8. Are you interested in learning how to control dental disease to preserve your teeth & oral health? ☐ YES ☐ NO
9. Have you had any unpleasant dental experiences? Do you have concerns we need to be aware of? ☐ YES ☐ NO
   If yes, explain: _____