

Welcome to our Practice!

Please list all medications that you are taking, both prescription and OTC:

Is there any disease, condition, or problem that you think that this office should know about that is not covered in the medical section? _____

Cell Phone (____) _____

Preferred method of contact: () Phone Home () Call/Txt Cell () E-Mail

How did you hear about our office? _____

DENTAL HISTORY

Date of last dental visit _____ Treatment Received _____

Date of last full mouth series of x-rays _____ Last bitewing x-rays _____

Is there anything you would like to change about your teeth? _____

I certify that the above information is complete and accurate.

Patient or Guardian's Signature _____ Date _____