Patient Information

Date:_____
Birth Date:_____

Name _____Age _____Sex _____Marital Status _____
LAST FIRST MIDDLE

Home Address _____ SS# _____-_____-_____

_____Home Phone _____
CITY STATE ZIP CODE

Employer _____ Occupation _____ Employed Since _____
Employer Address _____ Work Phone _____
Emergency Contact Person _____ Phone _____
Who may we thank for referring you to our office? _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birth Date _____ SS# _____-_____-_____ Work Phone _____Home Phone _____
Insurance Company _____ Group # _____ Insurance Phone _____

If you have additional insurance, please complete the following

Name of Insured _____ Relationship to Patient _____
Birth Date _____ SS# _____-_____-_____ Work Phone _____Home Phone _____
Insurance Company _____ Group # _____ Insurance Phone _____

Last dental visit _____ ***Name of former Dentist and Location*** _____
Reason for today s visit_____

Please answer the following questions

Does your gum bleed when you brush your teeth? Y N

Do you notice food getting caught between your teeth? Y N

Are any of your teeth sensitive for longer than ten seconds after you had something hot, cold, or sweet? Y N

Do you have any spontaneous discomfort in any of your teeth even in the absence of any hot or cold stimulation? Y N

Do you have any sensitivity when biting down hard? Y N

Do you have any loose teeth? Y N

Do you have any discomfort with your jaw joint in opening or closing your mouth? Y N

Do you have any discomfort anywhere else in your face or jaw? Y N

Do you have any difficulty in chewing your food? Y N

Have you had any head, neck, or jaw injuries? Y N

Do you have frequent headaches? Y N

Do you clench or grind your teeth? Y N

Do you snore? Y N

Do you usually feel well rested in the morning? Y N

Have you had orthodontic treatment? Y N

Are you concern about the color of your teeth? Y N

Are you concern about the shape of your teeth? Y N

Are you concern about mouth odor? Y N

If you wear dentures or partials, when was the date of placement? _____

Is it very important to you to save all of your teeth? Y N