Patient Information

Patients Name: _____ Sex: M F Birthday_____ Age_____

Home Phone: _____ Home Address: _____

City: _____ St: _____ Zip: _____

Are you a full time student: Yes___ No___ Name of School: _____

If employed: Occupation _____Employer: _____ Patients SSN #_____

Your employer address: _____ Work #_____

Responsible Parent/Guardian

1. Full Name_____ Relation: _____ Birth date: _____

SSN# _____ Employers Name: _____ Employers Adress_____

Work Number: _____

2. Full Name_____ Relation: _____ Birth date: _____

SSN# _____ Employers Name: _____ Employers Address_____

Work Number: _____

Person Responsible for account: _____ Referred to us by_____

Reason for this visit: _____

Emergency Information, A relative not living with you:
(Name & Number)_____

Insurance Information

Dental Insurance Information (Primary Carrier)	**Secondary Information**
Insured's Name:	Insured's Name:
Insurance Co.	Insurance Co.
Insurance Co. Address	Insurance Co. Address
Insured Employer	Insured Employer
Insured SSN#:	Insured SSN#:
Group # Local #	Group # Local #
Drivers License #	Drivers License #

Dental History	History	
Previous Dentist Name:		
City: Phone:		
How long since you have seen a Dentist		
Last Complete Dental Exam. Date:		
Last Full Mouth X-Rays. Date:		
	Yes	**No**
Are you having any problems now?		
What?		
Do you wear Dentures? (partials or full)		
Are you unhappy with your dentures?		
Would you like to know more about permanent replacements?		
Are you apprehensive about dental treatment?		
Have you had any Periodontal (gum) treatment?		
Do your gums bleed, or feel tender, or irritated?		
Are your teeth sensitive to hot, cold, sweets, or pressure?		
Are you unhappy with the appearance of your teeth?		
Are you aware of grinding or clenching your teeth?		
Do you have headaches, earaches, or neck pains?		
Do you have loose, tipped, or shifting teeth? (Circle)		
Have you worn braces on your teeth? (orthodontics)		
Do you have discolored teeth that bother you?		
Would you like your smile to look better or different?		
Do you have problems with teeth/fillings breaking?		
Do you regularly use dental floss?		
Are you aware of being allergic to or reacting adversely to any medications or substances? If yes please list.		