

WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Occupation _____
 SS/HIC/Patient ID # _____ Patient Employer/School _____
 Patient Name _____ Employer/School Address _____
 Address _____
 City _____ Employer/School Phone (____) _____
 State _____ Zip _____ Spouse's Name _____
 E-mail _____ Birthdate _____ SS# _____
 Spouse's Employer _____
 Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
 Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____ Is patient covered by secondary insurance? Yes No
 Relationship to Patient _____ Subscriber's Name _____
 Birthdate _____ SS# _____ Relationship to Patient _____
 Insurance Co. _____ Birthdate _____ SS# _____
 Group # _____ Phone (____) _____ Insurance Co. _____
 Group # _____ Phone (____) _____

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext. Alt. (____) _____
 Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
 Home (____) _____ Work (____) _____ Ext. Alt. Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____
 Former Dentist _____
 City/State _____
 Date of last dental visit _____
 Date of last dental X-rays _____
 How often do you floss? _____
 How often do you brush? _____
 Do you wear contact lenses? Yes No

Please check () "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No