

Welcome to our office! We hope that you will have a pleasant experience. Please take a few minutes to answer the following questions as completely as you can. This information is confidential.

Patient's Name _____ Age _____ Home Phone () _____
Address _____ Work Phone () _____
City _____ State _____ Zip _____ Other Phone () _____
Birthdate _____ SSN _____ Driver's Lic. # _____
Marital Status: Single Married Widowed Separated Divorced Sex: Male Female

Employer/Occupation _____ Address _____
In case of emergency, contact: _____ Relationship _____ Phone () _____
Referred by: _____ If student, name of school _____

If the person responsible for this account is different than the patient, please fill in this section:

Name _____ Relationship _____ Home Phone () _____
Address (if different from above) _____ Work Phone () _____
City _____ State _____ Zip _____ Other Phone () _____

PRIMARY DENTAL INSURANCE (Leave blank only if no dental benefits)

Name of Ins. Co. _____ Name _____ Relationship _____
Address of Co. _____ Address (if different from above) _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Phone _____ Group # _____ Birthdate _____ SSN _____
Policy # _____ Employer _____

SECONDARY DENTAL INSURANCE (Leave blank only if no dental benefits)

Name of Ins. Co. _____ Name _____ Relationship _____
Address of Co. _____ Address (if different from above) _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Phone _____ Group # _____ Birthdate _____ SSN _____
Policy # _____ Employer _____

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

Patient/ Parent or Guardian Signature _____ Date _____

DENTAL HISTORY Reason for today's visit _____ Date of last dental visit _____

Are you happy with the appearance of your smile? If no, explain _____

Date of last dental cleaning _____ Date of last dental x-rays _____

Do you think you have any cavities? _____ How often do you brush? _____ Floss? _____

Place a mark on "yes" or "no" if you have had any of the following:

Bad breath	<input type="checkbox"/> yes <input type="checkbox"/> no	Food caught between teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Periodontal tx.	<input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding gums	<input type="checkbox"/> yes <input type="checkbox"/> no	Grinding or clenching teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to cold	<input type="checkbox"/> yes <input type="checkbox"/> no
Blisters on lips of mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Gums swollen or tender	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to hot	<input type="checkbox"/> yes <input type="checkbox"/> no
Burning sensation on tongue	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaw pain or tenderness	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to sweets	<input type="checkbox"/> yes <input type="checkbox"/> no
Chew on one side of mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Lip or cheek biting	<input type="checkbox"/> yes <input type="checkbox"/> no	Sensitivity to biting	<input type="checkbox"/> yes <input type="checkbox"/> no
Prolonged bleeding following extractions	<input type="checkbox"/> yes <input type="checkbox"/> no	Loose teeth	<input type="checkbox"/> yes <input type="checkbox"/> no	Sores or growths in your mouth	<input type="checkbox"/> yes <input type="checkbox"/> no
Clicking or popping jaw	<input type="checkbox"/> yes <input type="checkbox"/> no	Broken fillings	<input type="checkbox"/> yes <input type="checkbox"/> no	Oral cancer	<input type="checkbox"/> yes <input type="checkbox"/> no
Dry mouth	<input type="checkbox"/> yes <input type="checkbox"/> no	Mouth breathing	<input type="checkbox"/> yes <input type="checkbox"/> no	Other _____	
Fingernail biting	<input type="checkbox"/> yes <input type="checkbox"/> no	Pain with brushing	<input type="checkbox"/> yes <input type="checkbox"/> no		
		Pain around ear	<input type="checkbox"/> yes <input type="checkbox"/> no		

If you have answered yes to any of the above, please explain. _____

