

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ Male Female
Last First MI Mr Mrs Ms Dr

Birthdate: _____ Age: _____ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: _____ Cell/other #: _____ Work Phone #: _____ Ext: _____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: _____ Home Phone #: _____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext: _____ Driver's License #: _____

Insurance Information

Primary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: _____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? Yes No Orthodontic Coverage? Yes No Medical Coverage? Yes No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: _____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Dental History

Why have you come to the dentist today?

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Your current dental health is Good Fair Poor

Do you floss daily? Yes No Brush daily? Yes No

Type of bristles on your toothbrush? Hard Medium soft

Do your gums ever bleed? Yes No Ever Itch? Yes No

Have you ever had periodontal disease? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? Yes No

Do you still have wisdom? Yes No

Previous / Present Dentist _____ Lost Visit Date- _____
(Please Circle)

Would you like fresher breath? Yes No Whiter teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change?

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____
Street

_____ City _____ State _____ Zip

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Phen-Fen, Reclux or Pondimin? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

week # _____ Are you nursing? Yes No

Do you or have you experienced the following?

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