

Date _____

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ Social Security # _____ Male _____ Female _____

Check Appropriate: ___Minor ___Single ___Married ___Separated ___Divorced ___Widowed

Spouse's Name _____ If Student, Name of School/College _____

Patient's Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

(if other than patient listed above)

Name of Person Responsible for Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ Social Security # _____ Is this Person Currently a Patient in our Office? _____

Employer _____ Work Phone _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Payment in full is expected at each appointment.

___Cash/Check ___Visa/MC/Discover ___I wish to discuss the office's payment policy

Patient Dental History

Name of Previous Dentist _____ Approx. Date of Last Exam/Cleaning _____

YES NO

- 1. Do your gums bleed while brushing or flossing? _____
- 2. Are your teeth sensitive to hot or cold liquids/foods? _____
- 3. Are your teeth sensitive to sweet or sour liquids/foods? _____
- 4. Do you feel pain to any of your teeth? _____
- 5. Do you have any sores or lumps in or near your mouth? _____
- 6. Have you had any head, neck, or jaw injuries? _____
- 7. Have you ever experienced any of the following problems in your jaw?
 - Clicking _____
 - Pain (joint, ear, side of face) _____
 - Difficulty in opening or closing _____
 - Difficulty in chewing _____
- 8. Do you have frequent headaches? _____
- 9. Do you clench or grind your teeth? _____
- 10. Do you bite your lips or cheeks frequently? _____
- 11. Have you ever had any difficult extractions in the past? _____
- 12. Have you ever had any prolonged bleeding following extractions? _____
- 13. Have you had any orthodontic treatment? _____
- 14. Do you wear dentures or partials? _____
 - If yes, date of placement _____
- 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? _____
- 16. Do you like your smile? _____