

WELCOME

To assist us in serving you, please complete the following confidential form.

Preferred name _____

Patient's name _____

Birthdate _____ SS# _____

Home phone _____ If minor, parent or guardian name _____

**May we send text message reminders? ___ YES or ___ NO / Cell # _____

Phone carrier: ___ Sprint / ___ AT&T / ___ T-Mobile / ___ Verizon / other _____

**May we send email reminders? ___ YES or ___ NO / Email: _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Work phone _____

Spouse's name _____ Spouse's employer _____

Unmarried

Whom may we thank for referring you to our office? _____

Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: Not covered by dental insurance

Your Dental Insurance Co.: _____ Policy # _____ Group number _____

Covered by secondary insurance? yes no

Secondary Dental Insurance Co: _____ Policy # _____ Group number _____

Subscriber's Name: _____ Birthdate: _____ SS# _____

In case of emergency, contact -- Name: _____ Relationship: _____

Home #: _____ Cell #: _____

DENTAL HISTORY

The information provided is important to your dental health.

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____

Date of last dental X-rays _____

Do you have or have you had any of the following?
(Please check any that apply)

- Bad breath
- Bleeding gums
- Blisters on lips or mouth
- Burning sensation on tongue
- Chew on one side of mouth

- Do you smoke or use chewing tobacco
- Clicking or popping jaw
- Dry mouth
- Fingernail biting
- Food collects between teeth
- Foreign objects
- Grinding teeth

- Gums swollen or tender
- Jaw pain or tiredness
- Lip or cheek biting
- Loose teeth or broken fillings
- Mouth breathing
- Mouth pain, brushing
- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitivity to cold
- Sensitivity to heat
- Sensitivity to sweets
- Sensitivity when biting
- Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

Women:

- May be pregnant
Expected delivery date: _____
- Nursing
- Taking hormones or contraceptives