WELCOME TO OUR OFFICE!
WE WOULD LIKE TO GET TO KNOW YOU BETTER…

1. PATIENT INFORMATION

DATE ____

PATIENT NAME ____________________________________

ADDRESS ____

____
CITY STATE ZIP

I PREFER TO BE CALLED : MR. MRS. MISS OTHER______________

BIRTHDATE ____________________ AGE: _________ GENDER: F M

PATIENT SS: (OPTIONAL)____________________________

OCCUPATION: ____________________________________

EMPLOYER: ______________________________________

SPOUSE'S NAME: __________________________________

SPOUSE'S OCCUPATION: ____________________________

SPOUSE'S EMPLOYER: ______________________________

IF PATIENT IS A MINOR, GIVE PARENT OR GUARDIAN'S NAME: __________

____

2. CONTACT INFORMATION

EMAIL: ____

PHONE NUMBERS: HOME ____________________________

CELL: ______________________________ CAN WE TEXT YOU? YES / NO

WORK: _________________________________ CAN WE CALL? YES / NO

PREFERRED CONTACT METHOD: HOME / CELL / TEXT / WORK / EMAIL

BEST TIME TO REACH YOU? AM OR PM

PREFERRED APPOINTMENT TIMES:

MON TUE WED THRS FRI AM / PM

3. IN CASE OF EMERGENCY, PLEASE CONTACT

NAME ____

RELATIONSHIP ___________________________________

HOME PHONE ____________________________________

CELL PHONE ____________________ WORK ____________________

BEST PHONE NUMBER TO CONTACT THEM? HOME / CELL / WORK

4. WHOM MAY WE THANK FOR REFERRING YOU?

FAMILY/FRIEND ___________________________________

OTHER ____

5. MEDICAL HISTORY

YOUR CURRENT PHYSICAL HEALTH IS:
GOOD FAIR POOR

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?
IF SO, PLEASE SPECIFY? YES NO

____

____

FAMILY PHYSICIAN'S NAME _________________________

PHYSICIAN'S PHONE ______________________________

ARE YOU TAKING ANY DRUGS OR MEDICATIONS?
IF SO, PLEASE LIST EACH ONE YES NO

____

____

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU OR HAVE YOU EVER BEEN AFFLICTED WITH THESE:

HEART AILMENT	YES	NO
DIABETES	YES	NO
RHEUMATIC FEVER	YES	NO
EPILEPSY	YES	NO
HIGH BLOOD PRESSURE	YES	NO
RESPIRATORY DISEASE	YES	NO
HEPATITIS	YES	NO
PROLONGED BLEEDING	YES	NO
HEALING COMPLICATIONS	YES	NO

ARE YOU ALLERGIC TO ANY MEDICATIONS?
IF SO, PLEASE LIST EACH ONE: YES NO

____

____

FOR WOMEN:

ARE YOU TAKING BIRTH CONTROL?	YES	NO
ARE YOU PREGNANT?	YES	NO
ARE YOU NURSING?	YES	NO

6. DENTAL INSURANCE INFORMATION

CARRIER____

RELATIONSHIP TO SUBSCRIBER______________________

SUBSCRIBER ID____________________OR SS#____________________

7. PAYMENT PLANS

ARE YOU INTERESTED IN 0% FINANCING PAYMENT PLANS? YES NO

8. WHAT SERVICES ARE YOU INTERESTED IN?

PREVENTATIVE SERVICES YES NO
COSMETIC CORRECTIONS SUCH AS….
- PORCELAIN VENEERS YES NO
- REPLACING OLD FILLINGS YES NO
- TMJ/TMD TREATMENT YES NO
- OTHER: ____

____

9. DENTAL HISTORY

1. ARE YOUR TEETH SENSITIVE TO:
   - HEAT YES NO
   - COLD YES NO
   - SWEETS YES NO
   - BITING PRESSURE YES NO
2. DOES FOOD CONSTANTLY GET STUCK BETWEEN CERTAIN TEETH IN YOUR MOUTH?
   YES NO
3. DO YOU GET FRUSTRATED BECAUSE YOU ALWAYS HAVE SOMETHING TO BE TREATED OR REPAIRED WHEN YOU VISIT A DENTIST? YES NO
4. ARE YOU DISSATISFIED WITH YOUR TEETH IN ANY WAY?
   YES NO
5. ARE YOU DISSATISFIED WITH THE WAY YOUR TEETH LOOK? FOR EXAMPLE: COLOR, SHAPE, SPACES, ETC.
   YES NO
6. DO YOU HAVE ANY FILLINGS THAT SHOW IN YOUR FRONT TEETH?
   YES NO
7. DO ANY OF YOUR FILLINGS SHOW WHEN YOU SMILE?
   YES NO
8. IF ANY OF YOUR MERCURY AMALGAM SILVER FILLINGS NEED REPLACEMENT, WOULD YOU PREFER TO HAVE MORE NATURAL, TOOTH-COLORED RESTORATIONS INSTEAD?
   YES NO
9. HAVE YOU EVER HAD ANY TEETH REMOVED?
   YES NO

   HOW LONG HAVE THOSE TEETH BEEN MISSING? ____________
10. DO YOUR GUMS BLEED WHEN BRUSHING?
    YES NO
11. DO YOU EVER AVOID ANY PART OF THE MOUTH WHILE BRUSHING?
    YES NO
12. HAVE YOU BEEN INSTRUCTED REGARDING PROPER HOME CARE?
    YES NO
13. DO YOU HAVE AN UNPLEASANT TASTE OR ODOR IN YOUR MOUTH?
    YES NO
14. DO YOU SMOKE? YES NO
15. DO YOU FREQUENTLY SNACK BETWEEN MEALS ON SWEETS, OR CHEW GUM? YES NO
16. HOW OFTEN DO YOU FLOSS? ____________________________
17. HOW OFTEN DO YOU BRUSH YOUR TEETH? ________________
18. WHEN WAS YOUR LAST DENTAL APPOINTMENT?_____________
19. WHAT DID YOU HAVE DONE?______________________________

    ____
20. HOW LONG SINCE YOUR LAST THOROUGH EXAMINATION WITH FULL MOUTH X-RAYS? __________________________________
21. WHAT PROMPTED YOU TO SEEK DENTAL CARE AT THIS TIME?

    ____

    ____
22. DO YOU WANT TO LEARN HOW TO CONTROL DENTAL DISEASE AND RETAIN YOUR HEALTH?
    YES NO
23. HAS THE FEAR OF DISCOMFORT KEPT YOU FROM REGULAR DENTAL VISITS?
    YES NO
24. ARE YOU DEEPLY CONCERNED ABOUT THE FINANCES REQUIRED TO RETURN YOU MOUTH TO EXCELLENT DENTAL HEALTH? YES NO

10. TMJ/TMD SCREENING

HAVE YOU EXPERIENCED?
- CLICKING OR POPPING OF THE JAW? YES NO
- DIFFICULTY OPENING / CLOSING MOUTH? YES NO
- PAIN IN YOUR:
  - JAW JOINT YES NO
  - EAR YES NO
  - SIDE OF FACE YES NO

DO YOU CLENCH OR GRIND YOUR TEETH YES NO
DO YOU HAVE SLEEP APNEA? YES NO

I CONSENT TO WHATEVER DENTAL PROCEDURES AND ANESTHETICS ARE NECESSARY FOR THE TREATMENT FOR THE PATIENT LISTED ON THIS FORM. I ALSO AGREE TO ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL TREATMENT RENDERED.

SIGNATURE (OR LEGAL GUARDIAN) ____ DATE ________________________