PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name:_____ Date of Birth:_____ Sex:_____ Age:_____

Home address:_____ City:_____ State:_____ Zip:_____

Billing address (if different):_____ City:_____ State:_____ Zip:_____

Home phone:_____ Cell:_____ Email:_____

Driver's license #:_____ State:_____ SS#:_____

Employer/Occupation:_____ Bus. Phone:_____

Spouse's name & phone #:_____ Emergency phone other than spouse:_____

Primary Dental Insurance:_____ Group # :_____

Secondary Dental Insurance:_____ Group #:_____

Subscriber's name:_____ Date of Birth:_____ SS #:_____

Name of your medical doctor:_____ Date of last visit to your doctor:_____

Name of previous dentist:_____ Date of last visit to dentist:_____

Referred to us by:_____ _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?_____	☐	☐
Have you had problems with previous dental treatment?_____	☐	☐
Do you gag easily?_____	☐	☐
Do you wear dentures?_____	☐	☐
Does food catch between your teeth?_____	☐	☐
Do you have difficulty chewing food?_____	☐	☐
Do you chew only on one side of your mouth?_____	☐	☐
Do you avoid brushing any part of your mouth because of pain?_____	☐	☐
Do your gums bleed easily?_____	☐	☐
Do your gums bleed when you floss?_____	☐	☐
Do your gums feel swollen or tender?_____	☐	☐
Have you ever notices slow healing sores in or about your mouth?_____	☐	☐
Are your teeth sensitive?_____	☐	☐
Do you have twinges of pain when your teeth come in contact with:		
Hot foods or liquids?_____	☐	☐
Cold foods or liquids?_____	☐	☐
Sours?_____	☐	☐
Sweets?_____	☐	☐
Do you take fluoride supplements?_____	☐	☐
Are you dissatisfied with the appearance of your teeth?_____	☐	☐
Do you prefer to save your teeth?_____	☐	☐
Do you want complete dental care?_____	☐	☐

	Yes	No
How often do you brush?_____		
How often do you floss?_____		
Does your jaw make a noise so that it bothers your or others?_____	☐	☐
Do you clinch your jaws frequently?_____	☐	☐
Do your jaws ever feel tired?_____	☐	☐
Does your jaw get stuck so that you can't open freely?____	☐	☐
Does it hurt when you chew or open wide to take a bite?_____	☐	☐
Do you have earaches or pain in front of the ears?_____	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?_____	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?_____	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?_____	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?____	☐	☐
Do you have temporomandibular (jaw) disorder (TMD)?__	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?_____	☐	☐
Are you unable to open your mouth as far as you want?__	☐	☐
Are you aware of an uncomfortable bite?_____	☐	☐
Have you had a blow to the jaw (trauma)?_____	☐	☐
Are you a habitual gum chewer or pipe smoker?_____	☐	☐

Submit