

PATIENT INFORMATION

Name _____ Preferred Name _____
Address _____
City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____
Social Security Number _____ Date of Birth _____
Whom may we thank for referring you to our practice? _____
Is the patient covered by dental insurance? _____ If so, please allow us to photocopy your insurance card.

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____
Employer _____ Social Security Number _____

DENTAL HISTORY

Reason for this appointment _____
Approximate date of last dental visit _____ Last complete dental examination _____
Last professional cleaning _____ Last full mouth x-rays (at least 16 views) _____
What are your main concerns? _____
How do you rate your dental health? _____ Do your gums bleed when you brush? _____
How do you take care of your teeth on a daily basis? _____
Do you wear complete or partial dentures? _____ If so, could they be improved? _____
Are you aware of clenching or grinding your teeth during the day or at night? _____
Is saving your teeth important to you? _____
Would you like your smile to look better or different? _____
List any factors which might keep you from having needed treatment: _____
Other important information concerning dental treatment: _____

PLEASE CIRCLE ANY OF THE FOLLOWING ABOUT WHICH YOU WOULD LIKE MORE INFORMATION

Whitening Bonding Braces Implants Sensitive teeth
Fixed replacement teeth Porcelain veneers TMJ problems

