PATIENT INFORMATION

Email _____

Cell or Pager # _____

Date _____

Patient _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

SS# _____ DOB _____

Patient's Employer _____ Address _____ Wk. Phone _____

Spouse's Name _____ SS# _____ DOB _____

Spouse's Employer _____ Address _____ Wk. Phone _____

Who referred you to our office? _____

In case of emergency, please notify _____ Phone _____

INSURANCE

Do you have insurance? _____ Your policy? _____ Spouses policy? _____ Insured's Social Security # _____

Insurance Co. Name _____ Group No. _____

To avoid misunderstandings regarding dental insurance, be aware that ALL PROFESSIONAL SERVICES RENDERED are CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our service on the basis that insurance companies will pay our fees.

DENTAL HEALTH HISTORY

Any previous dentist? Name _____ _____

Has your dental care been:

☐ Regular (yearly) ☐ Intermittent (when necessary) ☐ Infrequent (when in pain) _____ Yes No

Do you feel apprehensive about visiting our office? _____ Yes No

Approximate date when your teeth were last cleaned? _____

When? _____

Are you dissatisfied with the appearance of your teeth? _____ Yes No

Have you ever experienced any of the following? _____ Yes No

☐ bleeding gums	☐ pus around the teeth	☐ foul odor
☐ swelling of gums	☐ loose teeth	☐ bad breath or bad taste
☐ pain or soreness in gums	☐ spaces between teeth	☐ food packing between teeth
☐ receding gums	☐ drifting of teeth	☐ high or rough fillings

Is there sensitivity in your teeth? _____ Yes No

☐ hot	☐ sweet	☐ tooth brushing
☐ cold	☐ biting	☐ pressure

Have you ever had an injury to your face, neck, or jaws? _____ Yes No

Do you suffer from pain in the face, neck or jaws? _____ Yes No

Remarks: _____

_____

_____