PATIENT INFORMATION and DENTAL HISTORY

Patient Name_____Nickname_____
Last First Middle

Residence_____
Street Address City State Zip

Home Phone_____ If less than one year at current address, give former address below:

_____
Street Address City State Zip

Patient's Date of Birth _____ Height_____ Weight _____ Marital Status _____

If patient is a minor: Guardian's Name _____ Relationship _____

Patient or Guardian's Employer _____ Business Phone _____

Business Address_____
Street Address City State Zip

(If married) Spouse's Name _____ Employer _____ Business Phone _____

(If student) School name _____ Grade _____ Interest/activities _____

Who Referred You to our Office?_____ ☐ Friend, family, other dentist ☐ Yellow pages
☐ Newspaper ☐ Internet ☐ Direct mailing

Responsible Party

Person Responsible for This Account _____ Relationship to patient _____

Driver's License#_____ State _____ Birthday _____ Employer _____

Insurance Information

Name of Primary Insured_____ Relationship to Patient _____

Birthday _____ Social Security # _____ Date Employment Started _____

Address of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Insurance Co. Phone _____

Insurance Company Mailing Address_____

Dental History **Indicate (check) which of the following conditions you are currently aware of:**

___ Pain due to heat___cold___or sweets
___ Pain when biting or chewing
___ Bleeding or receding gums or mouth odor
___ Tired or sore jaws after talking or eating
___ Problems with past dental care
___ Clench or grind your teeth during the day___ night ___
___ TMJ or jaw joint damage
___ Food catches between your teeth
___ Fear dental treatment
___ Want nitrous oxide treatment visits
___ Want stereo headphones for visits
___ Want headphones & nitrous oxide
___ Want to be more sedated Oral _____ IV _____
___ Unhappy with appearance of my smile

Is there anything else you are concerned with? _____

What is the reason for your visit today?_____

Why did you choose our office?_____

What would you like to change about your teeth or smile?_____

If you could change anything about your mouth or appearance what would be most important?_____

_____

Is there anything else you would like to know about our office?_____

By signing below I certify this information is accurate and give consent for treatment.

Signature of Patient, Parent, or Guardian _____ Date _____