PATIENT INFORMATION and DENTAL HISTORY

Patient Name _____ Preferred name_____
Last First Middle Initial

Residence _____
Street Address City Zip

Home/Cell 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 _____

Dental 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 apply:**

___ Unhappy with appearance of my smile
___ Want straighter teeth
___ Want whiter teeth
___ 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
___ Pain when biting or chewing
___ Bleeding or receding gums or mouth odor
___ Want to be sedated Oral _____ IV _____
___ Pain to Heat ____ Cold ____

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

_____

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

_____

What is the reason for your visit today? _____

Why did you choose our office? _____

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 _____