**Welcome to Our Office**

**PERSONAL INFORMATION**

Name: jvon\_2 (First Name Last Name) Date of Birth: (MM/DD/YYYY) Sex: jvon\_3

Address: jvon\_4

Home Phone#: jvon\_5 Cell Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: jvon\_6 confirm consent to receive appointment reminders through email

Referred by: jvon\_7

Do you have dental coverage?­ jvon\_9

**DENTAL HISTORY**

Please record previous dentist name and phone number if applicable: jvon\_8

Do you have any dental problems or concerns presently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle Yes or No for the following: (If Yes, please fill in details)

jvon\_\_10 Do you have sensitivity to temperature or pressure?

jvon\_\_11 Do your gums bleed when you brush your teeth?

jvon\_\_12 Do you grind/clench your teeth?

jvon\_\_13 Do you have any cracking or clicking of your jaw?

**MEDICAL HISTORY**

Emergency Contact: jvon\_\_14 Phone#: jvon\_\_15 Relationship: jvon\_\_16

Family Physician: jvon\_\_17 Physician Phone#: jvon\_\_18 Care Card:

Circle any of the medical conditions below that you have had or currently have.

jvon\_\_19

Are there any medical conditions we have not discussed that you feel we should be aware of? jvon\_\_20

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Signature of patient, parent or guardian: jvon\_\_21 Date: jvon\_1