Welcome

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑Male ❑ Female
Last First MI Mr. Mrs. Ms. Dr.

Birthdate: ____/____/____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone: (____) _____ Cell/other: (____) _____ Work Phone: (___) _____ Driver's License #: _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Spouse Name: _____ Spouse Employer: _____ Spouse Work Phone: (____) _____

Emergency Contact (other than residence): _____

Relation: _____ Home Phone: (_____) _____ Cell Phone: (_____) _____

Insurance Information

Insurance Co. Name: _____ Phone #: (_____) _____

Insured's Employer: _____ Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Insured's Social Security #:_____ Insured's Birthdate: ____/____/____

Dental History

Why have you come to the dentist today? _____

Are your teeth sensitive to heat, cold or anything else? _____

Are you happy with the way your smile looks? ❑ Yes ❑ No If not, what would you change? _____

Are you currently in pain? ❑ Yes ❑ No
Your current dental health is? ❑ Good ❑ Fair ❑ Poor
Have you ever had periodontal disease? ❑ Yes ❑ No
Do you floss daily? ❑ Yes ❑ No Brush Daily? ❑ Yes ❑ No
Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft
Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No
Would you like fresher breath? ❑ Yes ❑ No
Are you interested in whitening? ❑ Yes ❑ No
Do you have mobility in your teeth? ❑ Yes ❑ No
Do you use tobacco? ❑ Yes ❑ No
Are you on a special diet? ❑ Yes ❑ No

Previous/Past Dentist: _____ Last Visit Date: _____

CONTINUED ON BACK