

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number \_\_\_\_\_

Today's date \_\_\_\_\_

First name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

I prefer to be called (nickname, etc.) \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of birth \_\_\_\_\_ Social security no. \_\_\_\_\_

Home phone ( ) - \_\_\_\_\_ Work phone ( ) - \_\_\_\_\_ Cell phone ( ) - \_\_\_\_\_

Primary contact number (please check one)  Home  Work  Cell Best time to call \_\_\_\_\_

Fax ( ) - \_\_\_\_\_ E-mail \_\_\_\_\_ Driver's license no. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

If the patient is a child

School \_\_\_\_\_ School phone ( ) - \_\_\_\_\_ Grade \_\_\_\_\_

Dental History

Reason for today's visit \_\_\_\_\_

Are you currently in pain?  Yes  No  
If so, please describe: \_\_\_\_\_

Do you have any dental problems now?  Yes  No  
If so, please describe: \_\_\_\_\_

Have you ever had trouble with a previous dental treatment?  Yes  No  
If so, please describe: \_\_\_\_\_

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam \_\_\_\_\_ Date of last cleaning \_\_\_\_\_ Date of last full mouth X-rays \_\_\_\_\_

Procedure(s) done at last dental visit \_\_\_\_\_

Previous dentist's name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone ( ) - \_\_\_\_\_

Why are you changing dentists? \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_ How often do you brush your teeth? \_\_\_\_\_

How often do you floss? \_\_\_\_\_ What type of bristles do you use?  Hard  Medium  Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) \_\_\_\_\_

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No