

We would like to get to know you better!

DATE: _____

I. Patient Information:

Title: Miss Ms. Mrs. Mr. Dr. Other _____

Name: _____

Last name, First, Middle Initial

Preferred Name

SSN _____ Date of Birth _____

Address _____ Home Phone _____

City _____ State _____ Zipcode _____

E-mail address _____ Cell phone _____ Fax _____

Employer _____ Occupation _____

Address _____ Phone _____

City _____ State _____ Zipcode _____

How did you hear about our office? _____

Whom may we thank for referring you? _____

II. The person financially responsible for this account:

Name _____ Phone _____

Cellphone _____

Relationship to patient _____ SSN _____

Address _____

City _____ State _____ Zipcode _____

Employer _____ Phone _____

Address _____

City _____ State _____ Zipcode _____

III. How will you be paying for services today? Cash Check Credit Card Debit/Most Card

Drivers License # _____ State _____

IV. In case of emergency, who should we notify outside of household:

Name _____ Relationship _____ Phone _____

Address _____

City _____ State _____ Zipcode _____

V. Do you have dental insurance? Yes No

Name of Carrier _____ Phone _____

Subscribers Name _____

Insured's ID/SSN _____ Group Number _____

VI. Dental information release consent:

I authorize release of any information necessary to process this claim _____

Dental History

1. What prompted you to seek dental care at this time? _____
2. When was your last dental appointment? _____
3. What did you have done? _____
4. How long since your last *thorough* examinations with *full mouth x-rays*? _____
5. Are your teeth sensitive to:

	YES	NO
Heat _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold _____	<input type="checkbox"/>	<input type="checkbox"/>
Sweets _____	<input type="checkbox"/>	<input type="checkbox"/>
Biting Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you noticed:

Swelling _____	<input type="checkbox"/>	<input type="checkbox"/>
Growths or sore spots in your mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
Toothaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste or odor in your mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums when brushing _____	<input type="checkbox"/>	<input type="checkbox"/>
Constantly getting food stuck between teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had:

Anesthesia (novocaine, lidocaine etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reaction to anesthesia _____	<input type="checkbox"/>	<input type="checkbox"/>
Teeth Removed _____	<input type="checkbox"/>	<input type="checkbox"/>
Excessive or prolonged bleeding after tooth removal _____	<input type="checkbox"/>	<input type="checkbox"/>
Serious problems associated with previous dental treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you:

Avoid any part of the mouth while chewing or brushing your teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
Have unattractive fillings that show when you smile _____	<input type="checkbox"/>	<input type="checkbox"/>
Floss Daily _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequently snack between meals on sweets or chew gum _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the fear of discomfort kept you from regular dental visits? _____
10. Would you prefer sedation-Nitrous Oxide (laughing gas)? _____

Tell Us About You

1. Have you ever had a favorite dentist? _____
2. What are your feelings about previous dental care? _____
3. What are you looking for in a new dentist or what are your expectations? _____
4. What is most important to you about your dental health? _____
Why? _____
5. Are you happy with the appearance of your smile? _____
6. If there were no barriers, what would you do to change your smile or teeth? _____
7. Do you wish your teeth could be whiter? ____ / Would you be interested in an inexpensive way to whiten them? ____
8. What is the key to retaining you as a long term patient in this practice? _____

Office Use Only

Dentist Review _____	Date _____	Dentist Review _____	Date _____
Dentist Review _____	Date _____	Dentist Review _____	Date _____

