I. Patients Information

Chart # ____________

How did you find out about our office? ________________________

Mr./Mrs./Miss. ____
Last Name *First Name* *Middle Name*

Home Address ____
Street Address *City* *State* *Zip Code*

Home Phone: ________________ Work Phone: ________________ Cell Phone: __________
Date of Birth: ________________ Age: ________ Male / Female
Drivers License # ________________ Social Security # ________________

Employer's Name: ________________ How longed Employed: ________________

Work Address ____
Street Address *City* *State* *Zip Code*

Person to Contact in Case of Emergency: ______________________ Phone # ________________
Relationship to Patient: ________________ Alternate # ________________

II. Insurance Information Parent/Responsible Party – INSURED EMPLOYEE

Mr./Mrs./Miss. ____
Last Name *First Name* *Middle Name*

Drivers License # _______________ Social Security# _______________ Date of Birth: __________

____
Name of Employer/Company *Date of Hire* *Employer Phone No.*

Work Address ____
Street Address *City* *State* *Zip Code*

Insurance Carrier: ____________________

III. Dual Insurance Information (complete if you or your spouse has additional coverage)

Mr./Mrs./Miss. ____
Last Name *First Name* *Middle Name*

Drivers License # _______________ Social Security# _______________ Date of Birth: __________

____
Name of Employer/Company *Date of Hire* *Employer Phone No.*

Work Address ____
Street Address *City* *State* *Zip Code*

Insurance Carrier: ____________________

Patient Dental History

Name of Previous Dentist: ______________________
Location: ___________________________________ Date of Last Exam: ____________________

Please Circle

Question			Question		
1. Do your gums bleed while brushing or flossing?	Y	N	8. Do you have frequent headaches?	Y	N
2. Are your teeth sensitive to hot or cold liquids/foods?	Y	N	9. Do you clench or grind your teeth?	Y	N
3. Are your teeth sensitive to sweet/sour liquids/foods?	Y	N	10. Do you bite your lips or cheeks frequently?	Y	N
4. Do you feel pain to any of your teeth?	Y	N	11. Have you ever had any difficult extraction in the past?	Y	N
5. Do you have any sores/lumps in or near your mouth?	Y	N	12. Have you ever had any prolonged bleeding following extraction?	Y	N
6. Have you had any head, neck, or jaw injuries?	Y	N	13. Have you had any orthodontic treatment?	Y	N
7. Have you ever experience any of the following problems in your jaw?			14. Do you wear full or partial denture?	Y	N
Clicking	Y	N	15. Have you ever received oral hygiene instructions?	Y	N
Pain (joint/ear)	Y	N	16. Do you like your smile?		
Difficulty in opening or closing	Y	N			
Difficulty in chewing	Y	N			