



PATIENT INFORMATION

Mr. Ms. Mrs. Dr.
 Name: _____
 Address: _____
 City/Postal Code: _____
 E-mail Address: _____
 Phone: _____ Cell: _____
 Birth Date: ___/___/___ Age: ___ Male Female
Month Day Year
 In Case of Emergency Please Contact: _____
 Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT

Self Spouse Parent Guardian Other
 Name: _____
 Address: _____
 Phone: _____ Cell: _____
 Birth Date: ___/___/___ Age: ___ Male Female
Month Day Year
 Employer: _____
 Work Phone: _____ EXT: _____
 Occupation: _____

REFERRAL

Who can we thank for your referral? _____
 Can we friend you on **facebook**? Yes No
 If yes what is your **facebook** Name? _____

INSURANCE INFORMATION

Primary Insurance – Name of insured: _____
 Insurance company: _____
 Policy# _____ Cert# _____
 Relation: Self Spouse Other Birth Date: ___/___/___
Month Day Year
Secondary Insurance – Name of insured: _____
 Insurance company: _____
 Policy# _____ Cert# _____
 Relation: Self Spouse Other Birth Date: ___/___/___
Month Day Year
 Credit Card #: _____
 EXPIRY: _____ **VISA** OR **MASTERCARD** ? (please circle)

DENTAL HISTORY

Previous Dentist: _____ Phone: _____
 Last Dental X-Rays: _____
 Last Cleaning: _____
 Any previous problems with dental treatment? _____
 Are you satisfied with the appearance of your teeth?
 Y N Explain: _____

PAST HISTORY

Y N Gum Surgery?
 Y N Orthodontics (Braces)
 Y N Endodontics (Root Canal)
 Y N Oral Surgery

- Wisdom teeth removal
- Dental Implants
- Crowns
- Bridges
- Dentures

PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:

TEETH

- Broken/Chipped/Cracked
- Missing Tooth or Teeth
- Decay
- Loose Teeth
- Mouth Breathing
- Difficulty Chewing
- Food Trap Areas
- Grinding or Clenching
- Oral Habits: _____

- Mouth Sores
- Sensitive to Hot/Cold
- Sensitive to Sweets
- Tooth Pain
- Sinus Problems
- Burning Tongue/Lips/ Dry Mouth
- Gum Surgery
- Shifting teeth

GUMS

- Bleeding/Sore Gums
 - Bad Breath
 - Sore or Sensitive
 - Swelling or Lumps
- Jaw/Facial Pain Problems**
- Facial Pain
 - Frequent Headaches
 - Jaw Clicks
 - Pain in Cheeks or Temples
 - Difficulty Opening

OTHER CONCERNS OR REASONS FOR VISIT?:

