PATIENT HISTORY INFORMATION

PATIENT INFORMATION

PATIENT'S NAME Last__________ First__________ Middle Initial____

SEX: M F BIRTHDATE:__________ S.S.#:____-____-____ REASON FOR VISIT:__________

If patient is a minor, name of Parent or Guardian:__________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?__________

RESPONSIBLE PARTY (person responsible for billing)

NAME Last__________ First__________ Middle Initial____ Marital Status______

ADDRESS__________ CITY__________ STATE______ ZIP______

MAILING ADDRESS__________ CITY__________ STATE______ ZIP______

HOW LONG @ THIS ADDRESS______ HOME PHONE ( )__________ WORK PHONE ( )__________

EMAIL ADDRESS__________ CELL PHONE ( )__________ FAX ( )__________

SOCIAL SECURITY NO____-____-____ BIRTHDATE__________ RELATION TO PATIENT__________

EMPLOYER__________ OCCUPATION__________ HOW LONG______

INSURANCE INFORMATION

PRIMARY

INSURED'S NAME__________

INSURANCE CO.__________

PHONE NO.__________ GROUP #__________

INSURED'S EMPLOYER__________

INSURED'S SS#____-____-____ DOB__________

SECONDARY

INSURED'S NAME__________

INSURANCE CO.__________

PHONE NO.__________ GROUP #__________

INSURED'S EMPLOYER__________

INSURED'S SS#____-____-____ DOB__________

DENTAL HISTORY

It is important that I know about your dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

LAST DENTAL VISIT__________ LAST COMPLETE EXAM__________ LAST X-RAYS__________

ARE YOU HAVING ANY PROBLEMS AT THIS TIME? Y N IF YES, WHAT?__________

NAME OF PREVIOUS DENTIST__________ PHONE__________

HOW DO YOU FEEL ABOUT THE HEALTH OF YOUR MOUTH__________

Is your present dental health POOR?..............................Y N

Do you wear DENTURES? (partials or full).......................Y N

Are you UNHAPPY with your denture.............................Y N

Would you like to know more about PERMANENT REPLACEMENTS........Y N

Are you APPREHENSIVE about dental treatment.............Y N

Have you had any PERIODONTAL TREATMENT (GUM).....Y N

Do your gums BLEED, feel TENDER, or IRRITATED.........Y N

Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)...Y N

Are you UNHAPPY with the APPEARANCE of your teeth...............Y N

Are you aware of GRINDING or CLENCHING...............................Y N

Do you have HEADACHES, EARACHES, or NECK PAIN.................Y N

Have you worn BRACES...Y N

Do you have DISCOLORED teeth that bother you.........................Y N

Would you like to your smile to LOOK DIFFERENT or BETTER........Y N

Do you REGULARY use DENTAL FLOSS.....................................Y N

FAMILY PHYSICIAN__________ PHONE__________

PHARMACY NAME__________ PHONE__________

IN CASE OF EMERGENCY, CONTACT__________ PHONE__________

PATIENT SIGNATURE__________ DATE__________

DENTIST SIGNATURE__________