We would like to get to know you better!!!!!

Date _____

Name: _____ Male ___Female___ Responsible Party: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth:_____ House Phone:_____ Cell Phone: _____

Email Address:_____ If minor, Parents Name:_____

Who referred you to our office? _____ When was your last Dental Appointment? _____

For Insurance Purposes:
Policy Holder:_____ Employer:_____ Work Phone: _____ Group Number:_____

Name of Insurance: _____Social Security Number: _____ Birthdate: _____

Are you covered by another plan? Y___ N ___

Name of Carrier: _____ Group Number: _____ Social Security Number: _____

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Are your teeth sensitive to:	Yes	No
Heat?	□	□
Cold?	□	□
Sweets?	□	□
Pressure?	□	□
Does food catch between your teeth?	□	□
Do your gums bleed when brushing?	□	□
Have you noticed any gum swelling around any teeth?	□	□
Do you have an unpleasant taste or odor in your mouth?	□	□
Problems of the jaw:		
Clicking of the jaw	□	□
Pain (joints, ear, side of face)	□	□
Difficulty opening or closing	□	□
Difficulty Chewing	□	□
Do you ever avoid any part of the mouth while brushing?	□	□
Have you had a reaction to a local anesthetic?	□	□
Are you dissatisfied with your teeth and their appearance?	□	□
Are you deeply concerned about the finances required to return your teeth to excellent dental health?	□	□
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	□	□
Do you smoke, vape, or chew tobacco?	□	□
Have you ever had any teeth removed?	□	□
Do you feel you will eventually wear dentures?	□	□
Do you have any dental fears?	□	□

	Yes	No
Do you have any general health problems	□	□
If so, please specify:_____		
_____		
Have you had surgery?	□	□
If so, please specify:_____		
_____		
Are you currently under physician's care?	□	□
Reason:_____		
Medications:_____		
To the best of your knowledge, are you or have you ever		
been afflicted with:	□	□
Heart Ailment_____		
Diabetes	□	□
Rheumatic Fever	□	□
Epilepsy	□	□
High Blood Pressure	□	□
Respiratory Disease	□	□
Hepatitis	□	□
HIV Positive	□	□
Prolonged Bleeding	□	□
Healing Complications	□	□
Allergy to any drugs_____	□	□
Are you pregnant? Month_____	□	□
Cancer_____	□	□

Why did you leave your last dentist? _____

What is your present dental problem? _____

Signature: _____ Date: _____

Printed Name: _____

Parent/ Guardian Signature (if Minor): _____ Date: _____