



Welcome to our office!

Please take a moment to share with us your information...

Patient Name: _____ Preferred name/nickname: _____

Home address/City/State/Zip Code: _____

Home telephone number: _____ Work phone: _____

Cell Phone: _____ Email address: _____

Age: _____ Date of birth: _____ Gender _____ Social security number: _____

Your occupation: _____ Marital Status: _____

If you are a student, please list the school you are attending: _____

How did you hear about our practice? _____

Hobbies/interests: _____

Parent/Guardian information...

Name: _____ Relationship to Patient: _____

Home address/City/State/Zip Code: _____

Home telephone number: _____ Work phone: _____

Cell Phone: _____ Email address: _____

Date of birth: _____ Social security number: _____

Your occupation: _____ Marital Status: _____

Insurance information...

Do you have dental insurance? _____ Primary card holder's name: _____

Primary card holder's employer: _____ Insurance company name: _____

Insurance company phone number: _____ Insurance company group number: _____

Primary card holder's date of birth: _____ Primary card holder's social: _____

Please list the member or subscriber ID number if one is provided: _____

Your relationship to the card holder: Self Spouse Child

Primary Emergency contact information...

Whom may we notify in case of an emergency? _____

Relationship to patient: _____ Best contact number: _____

Address: _____

In case we cannot reach your primary emergency contact person ...

Who ELSE may we notify in case of an emergency? _____

Relationship to patient: _____ Best contact number: _____

Address: _____



Dental History

Please answer the following questions so that we may provide optimum care for you...

What concerns you about the way your teeth look? _____

How long has it been since your last dental visit? _____ Were dental x-rays taken? _____

General Dentist's name: _____ General Dentist's phone number: _____

Was there any recommended dental treatment not completed? _____

Have you ever been evaluated for Orthodontic treatment? Yes No If yes, when? _____

Have you ever sucked your thumb or finger? Yes No If yes, from _____ to _____

Do you feel nervous about having treatment? Yes No

Have you ever had an unpleasant experience at a dental office? Yes No

Are your teeth sensitive to: Heat Cold Biting Pressure Sweets

Does your jaw pop or click? Yes No Do you have frequent headaches? Yes No

Do you ever have pain in your jaw region? Yes No

Have you ever had braces or other orthodontic treatment? Yes No If yes, from _____ to _____

Have you ever had or been recommended for speech therapy? Yes No If yes, when _____

Does food constantly get stuck between your teeth? Yes No

Do you brush daily? Yes No Do your gums ever bleed when you brush? Yes No

Do you floss daily? Yes No Do your gums ever bleed when floss? Yes No

Is there ever an unpleasant taste or odor in your mouth? Yes No Do you smoke or use tobacco? Yes No

In general, how do you feel about your overall dental health? _____

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? _____

The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant if there is any change in my medical or dental status.

Patient Signature (aged 18 and over): Date: Doctor's Signature: Date:

Parent/Guardian Signature: Date: Doctor's Signature: Date: