

# PATIENT INFORMATION

Who introduced you to our office \_\_\_\_\_ Date \_\_\_\_\_  
Patient's name \_\_\_\_\_ Spouse's name \_\_\_\_\_  
If student, name and address of school \_\_\_\_\_  
Home address \_\_\_\_\_  
STREET CITY STATE ZIP  
Home telephone \_\_\_\_\_ Work telephone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_  
Patient's birthdate \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  Separated  
Responsible Party: Name \_\_\_\_\_  Mother  Father  Legal guardian  
Employer \_\_\_\_\_ Position \_\_\_\_\_ How long \_\_\_\_\_  
Employer's address \_\_\_\_\_  
STREET CITY STATE ZIP  
Spouse's name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Spouse's employer \_\_\_\_\_ Position \_\_\_\_\_ How long \_\_\_\_\_  
Address \_\_\_\_\_ Work # \_\_\_\_\_  
STREET CITY STATE ZIP  
Name of a relative not living with you \_\_\_\_\_  
Address \_\_\_\_\_ Telephone # \_\_\_\_\_

## DENTAL INSURANCE 1ST COVERAGE

Employee name \_\_\_\_\_  
Employee date of birth \_\_\_\_\_  
Employer \_\_\_\_\_ # Yrs. \_\_\_\_\_  
Name of Insurance Co. \_\_\_\_\_  
Program or policy # \_\_\_\_\_  
Union local or group \_\_\_\_\_  
Social security # \_\_\_\_\_

## DENTAL INSURANCE 2ND COVERAGE

Employee name \_\_\_\_\_  
Employee date of birth \_\_\_\_\_  
Employer \_\_\_\_\_ # Yrs. \_\_\_\_\_  
Name of Insurance Co. \_\_\_\_\_  
Program or policy # \_\_\_\_\_  
Union local or group \_\_\_\_\_  
Social security # \_\_\_\_\_

## DENTAL HISTORY

Previous dentist \_\_\_\_\_ City \_\_\_\_\_  
Approximate date of last dental visit \_\_\_\_\_ Approximate date when teeth were last cleaned \_\_\_\_\_  
Approximate date last full set of x-rays (generally 18 films or panorex) \_\_\_\_\_  
How often do you visit a dentist? \_\_\_\_\_ Do you use dental floss? \_\_\_\_\_  
How often do you brush your teeth? \_\_\_\_\_  
Are you currently experiencing pain in your mouth? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you presently have a sore or sores in your mouth ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you frequently have sores, mouth ulcers or fever blisters in your mouth or on your lips? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you have unreplaced missing teeth? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Were replacements ever suggested? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Do your gums bleed when brushing your teeth? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever been told you had gum problems? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Is any part of your mouth sensitive to (circle): pressure, chewing, temperature, sweet foods?  
If so, where? \_\_\_\_\_  
Does food catch between your teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ If so, where? \_\_\_\_\_  
Are you satisfied with your teeth and their appearance? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you feel that in the past you have required a lot of dental work? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, has it been to replace previous dentistry or new decay? ..... Replace \_\_\_\_\_ New decay \_\_\_\_\_  
Do you feel that you will lose more teeth and eventually have to wear full dentures? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever had local anesthetic (Novocaine, Xylocaine, etc.)? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you had any serious trouble associated with any previous dental treatment? ..... Yes \_\_\_\_\_ No \_\_\_\_\_  
Is so, please explain \_\_\_\_\_  
Does dental treatment make you nervous? ..... No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_  
Would you desire to be pre-sedated with Nitrous Oxide? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

