Patient Information

Patient Name: ____ Date:_____________
Last, First MI
Gender: ___________ Family Status: ________________ Social Security #:_________________
Phone (Home):______________ (Cell):________________ (Work):_____________ Ext:_________
Address: ____
Street Apartment #
____
City State Zip Code
Email: ____

Spouse or Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other Birth Date: ______________
Name: ___________________________________ SSN#________________________________
Phone: (Home):________________ (Cell):__________________ (Work):_____________ Ext:______
Address: ____
Street Apartment #
____
City State Zip Code

Dental Information

Date of Last Dental Visit:___________ were x-rays taken? Y N Reason for this visit:_____________
How often do you brush?________ Floss?________ Do your gums bleed? Y N Bad breath/taste? Y N
Do you grind your teeth? Y N Do you wear a nightguard? Y N Do you have a strong gag reflex? Y N
Any discomfort/sensitivity or pain? Y N If yes, please describe:______________________________
Do you have pain in your jaw joints? Y N Difficulty opening your mouth? Y N
Are you please with the appearance of your teeth? Y N If no, please describe what you would change.
____
What are your long term dental health goals?_____________________________________
What do you want your teeth to look like in 5 years? _______________________________
What do you want your smile to look like in 5 years? _______________________________
Have you ever had a dental emergency or complication following a dental procedure? Y N.
If yes, please describe. ____