WELCOME!

So that we may provide you with the best care possible, please complete these forms as accurately as possible. All information is strictly confidential.

Name _____ Date _____
I prefer to be called _____ Home Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Date of Birth _____ ❑ Male ❑ Female Email Address _____
Social Security # _____ Age _____ How would you prefer to confirm your appointment?
Marital Status _____ ❑ Phone or ❑ Email
Name of Spouse _____
Your Occupation _____
In case of emergency notify: _____ Phone # _____
Do you have dental insurance? ❑ Yes ❑ No Name: _____
Person responsible for payment: Name _____
Address _____ Employer _____
Whom may we thank for referring you to our office? _____

1. What is the main reason for your appointment? _____
_____
2. Date of last dental visit _____ Last dental cleaning _____
3. Do you have any dental problems now? ❑ Yes ❑ No For how long? _____
   If yes, please describe: _____
4. Do you:
   YES NO Clench or grind your teeth? ❑ Day ❑ Night
   YES NO Notice sensitive teeth? ❑ Cold ❑ Hot ❑ Biting or Chewing
   YES NO Smoke or chew tobacco?
   YES NO Notice mouth odors or bad taste?
   YES NO Notice popping or clicking of the jaw?
   YES NO Have difficulty chewing comfortably on both sides of your mouth?
   YES NO Is there anything you dislike about the appearance of your teeth? Please explain _____
_____
_____
5. Are you nervous about having dental treatment? ❑ Yes ❑ No
   If yes, what is your biggest concern? _____
6. Have you ever had periodontal (gum) treatment? ❑ Yes ❑ No Describe _____
7. Please list anything that you think would help us treat you better or more comfortably. (Questions, concerns, past problems you've had). _____
_____
_____