LAKE HILLS FAMILY DENITSTRY

Patient Information

Welcome to our office! Please complete this form. The information is important and allows us to provide you with the very best care. As required by law, our office adheres to written policies and procedures to protect the privacy of your information. Your answers are for our records only.

Patient Name: _____ Drivers Lic.#: _____

Preferred Name: _____ DOB: _____ SSN#_____

Spouses/Partners Name: _____ Parent/Guardian: _____

Home Address: _____ City: _____State: _____ Zip: _____

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

Please check your preferred contact for appointment confirmations

☐ Home # (_____) _____ ☐ Cell # (_____) _____ Work # (_____) _____Email: _____

Medical Doctor's name: _____ Phone: (_____) _____ Date of last visit: _____

Previous dentist name: _____ Phone: (_____) _____ Date of last visit: _____

Would you like us to request your records from your previous dentist? YES NO

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Insured Name: _____ DOB: _____ Employer: _____

Primary Dental Insurance: _____ Subscriber ID# _____ Group #: _____

Primary Insurance Address: _____ Primary Insurance Phone #: _____

SECONDARY INSURANCE INFORMATION

Secondary Insured Name: _____ DOB: _____ Employer_____

Secondary Dental Insurance: _____Subscriber ID# _____ Group # _____

Secondary Insurance Address: _____Secondary Phone #_____

DENTAL HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Have you had problems w/previous treatment?	☐	☐	Have you had periodontal (gum) treatment?
☐	☐	Do you gag easily?	☐	☐	Have you had Orthodontic (Braces: Treatment?
☐	☐	Do your gums feel swollen or tender?	☐	☐	Do you wear partial dentures or dentures?
☐	☐	Do your gums bleed when your brush or floss?	☐	☐	Do you have a dry mouth?
☐	☐	Does food /floss catch between your teeth?	☐	☐	Do you have slow healing sores in or around your mouth?
☐	☐	Do you have difficulty chewing your food?			
☐	☐	Do you avoid brushing part of your mouth?	☐	☐	Does your jaw click, pot or hurt?
☐	☐	Are your teeth sensitive-hot/cold/sweet/pressure?	☐	☐	Any face/cheek/joint/throat/temple pain?
☐	☐	Do you clench your teeth frequently?	☐	☐	Do you have an uncomfortable bite?
☐	☐	Are you currently experiencing dental pain or Discomfort? If yes describe: _____	☐	☐	Are you satisfied with your smile?

What is the reason for your dental visit today? _____

How often to you brush and floss? _____

Signature: _____ Date: _____