A Lifetime of Smiles

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We would like to get to know you better!

Date: _____

Patient Name: _____ **SS#** _____-____-_____ **Male** □ **Female** □ **Unspecified** □
Patient's Date of Birth _____/_____/_____ Age _____ **Marital Status** (circle): Single /Married / Other

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

Occupation: _____ Employer: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____

Spouse or Parent/Guardian _____D.O.B. ___/___/____SS# Spouse/Parent ____ -___-____

Address (if different than above): _____ Work #: _____

Spouse/Parent Occupation: _____ Employer_____

Dental Insurance Information If no insurance please check here □ **Primary Insurance**: See copy of card: □

Name of Dental Carrier: _____Subscriber #/Member ID: _____

Address: _____ Subscriber Employer: _____

Subscriber Name: _____ Insurance Phone Number: _____

Group Number: _____ S.S. Number (Subscriber) ____-___-____ Subscriber D.O.B.: _____/_____/_____

Is anyone other than yourself responsible for your dental treatment? _____

How did you hear about our office? _____

Other family members that we treat? _____

When was your last dental appointment? _____ Where? _____

Why did you leave your last dental office? _____

What is your present dental need? _____

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Are your teeth sensitive to:	**YES**	**NO**		**YES**	**NO**
Hot?	□	□	Have you noticed any gum swelling around any teeth?	□	□
Cold?	□	□	Difficulty opening and closing?	□	□
Sweets?	□	□	Difficulty chewing?	□	□
Biting Pressure?	□	□	Have you had a reaction to local anesthesia?	□	□
Pain (joints, ear, side of face)?	□	□	Do you have an unpleasant taste or odor in your mouth?	□	□
Do your gums bleed when brushing?	□	□	Are you dissatisfied with your teeth (appearance)?	□	□
			Have you ever had any teeth removed?	□	□
Problems of the Jaw:			How long have these teeth been missing? _____		
Clicking of the jaw?	□	□	Do you have any dental fears?	□	□