

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_

IF A CHILD,  
PARENT'S NAME \_\_\_\_\_

RESIDENCE-STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

HOME TEL. # \_\_\_\_\_ CELLULAR # \_\_\_\_\_

BUSINESS TEL. # \_\_\_\_\_ FAX # \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_

SPOUSE'S BUSINESS TEL. # \_\_\_\_\_

REFERRED BY \_\_\_\_\_

WHO WILL PAY  
THIS ACCOUNT \_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE? YES\_\_\_ NO\_\_\_

DATE OF BIRTH \_\_\_\_\_

**PAYMENT IS EXPECTED**  
**AT TIME OF TREATMENT**

(OVER)

## DENTAL INFORMATION

What is the reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_

Date of last dental exam and cleaning \_\_\_\_\_

Date of last full series of x-rays \_\_\_\_\_

Name of previous dentist \_\_\_\_\_

Tel. # \_\_\_\_\_ address \_\_\_\_\_

How many times per year do you have your teeth  
cleaned? \_\_\_\_\_

Do your gums bleed? Y\_\_ N\_\_

Do you feel like you have bad breath or a bad taste? Y\_\_ N\_\_

Does your jaw cause pain upon opening or closing? Y\_\_ N\_\_

Do you have trouble chewing? Y\_\_ N\_\_

Do you wake up with a sore jaw? Y\_\_ N\_\_

Have you ever noticed yourself grinding or clenching your teeth?  
Y\_\_ N\_\_

Do you feel you have adequate teeth to chew with? Y\_\_ N\_\_

Are any of your teeth sensitive to: cold?\_\_ hot?\_\_ sweets?\_\_ chewing  
pressure?\_\_

Do you feel your teeth are white enough? Y\_\_ N\_\_

Is there anything about your smile or teeth you would like to change or discuss?  
If so, what? \_\_\_\_\_