

In an effort to serve you better, we ask that you complete the following. We will be glad to assist you. Please Print Clearly.

Patient Information

A Parent or Guardian will be responsible for decisions on my treatment: Yes No

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth / / Home Tel: () _____ Work Tel: () _____
M D Y

Gender: Male Female Cell: () _____ Email: _____

Emergency Contact: _____ Contact's Phone: () _____

Family Doctor: _____ Dr.'s Phone: () _____

Financial Information

Person responsible for financial matters: Self Spouse Parent/Guardian Other

Primary Insurance

Ins. Company: _____ Insurance Details: _____

Employer/Policy Holder: _____

Policy #: _____ Certificate #: _____

Max Cov.: _____ % Coverage for: Basic _____ Maj. Restorative _____ Orthodontic _____

Secondary Insurance

Ins. Company: _____ Insurance Details: _____

Employer/Policy Holder: _____

Policy #: _____ Certificate #: _____

Max Cov.: _____ % Coverage for: Basic _____ Maj. Restorative _____ Orthodontic _____

Dental History

1. What is the reason for your visit today? Emergency Examination Other _____

2. How frequently do you visit a dentist? 3-6 months Annually Other _____

3. When was your last dental visit? _____ Last X-ray? _____

4. How often do you brush per day? _____ Floss? _____ Use Anti-bacterial rinsc? _____

5. Are your teeth sensitive to: Cold Heat Sweets Other _____

6. Do your gums bleed when: Brushing Flossing Never Other _____

7. Do your jaws crack, pop or grate when you open widely? Yes No

8. Do you regularly grind or clench your teeth? Yes No

9. Have you ever had any problems with previous dental treatments? Specify _____

10. Have you ever had any of the following? Bridgework Crowns or Caps Full or Partial Dentures
 Orthodontic (braces) Periodontal (Gum Surgery) Root Canal