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PATIENT INFORMATION	CONTACT INFORMATION
Patient's Name:______ Today's Date:______ SSN:______ Home Address:______ City:______ State:______ Zip:______ DOB:______ Age:______ Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Widowed Driver's License #:______ Occupation:______ Employer:______ Spouse's Name:______ Spouse's Occupation:______ Spouse's Employer:______ Whom may we thank for referring you?______	Home Phone #: ( )______ Work Phone #: ( )______ Cell Phone #: ( )______ E-Mail Address:______ Best time and place to reach you:______ ______ **IN CASE OF EMERGENCY, CONTACT:** Name:______ Relationship:______ Home Phone: ( )______ Work Phone: ( )______ **SPOUSE** Work Phone: ( )______ Cell Phone: ( )______

INSURANCE INFORMATION

Who is responsible for this account?______ Relationship to patient:______
Insurance Company:______ Group #:______
Birthdate:______ SSN:______ Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name:______ Relationship to patient:______
Birthdate:______ SSN:______ Insurance Company:______ Group #:______

DENTAL HISTORY

Reason for today's visit:______ Previous Dentist:______ City:______
How Long:______ Date of last cleaning:______ Date of last x-ray:______
Why did you leave your last dentist?______ What did you like most?______ Least?______

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR CURRENTLY HAVE:

- ☐ Mouth Discomfort
- ☐ Periodontal Treatment
- ☐ Trenchmouth or Pyorrhea
- ☐ Gum Abscesses
- ☐ Gums bleed when brushing
- ☐ Trouble Chewing/Speaking
- ☐ Immediate relatives that have lost all of their natural teeth
- ☐ Grind or Clench teeth
- ☐ Pain, Clicking, Popping in jaw joints
- ☐ Orthodontic Treatment
- ☐ Mouth Odor or Bad Taste
- ☐ Cold Sores or Fever Blisters
- ☐ Other Oral Lesions
- ☐ Complications with or following previous Dental or Oral surgical treatment
- ☐ Bad Dental Experience
- ☐ Loose or shifting teeth
- ☐ Bruise easily
- ☐ Sensitive teeth
- ☐ Fear of dental treatment
- ☐ Awake with sore jaw

If you could change one thing about your smile, what would it be?______

If there was a simple way to whiten your teeth, would you be interested? ☐ Yes ☐ No