Patient Information

Our practice is committed to providing each patient with individualized comprehensive care consistent of your particular needs, wants, and values. By answering the following questions candidly you will help us to better understand your dental concerns and expectation. Your answers are for our records only and will remain confidential.

Spouse Name: _____ Birth date: _____ SS#:_____

Employer Name: _____ Address: _____

Person for Emergency Contact: _____ Phone: _____

Primary Insurance:

Insurance Co Name: _____ Group/Policy#:_____

Name of Insured: _____ Insured SS#:_____

Insured Birth Date: _____

Employer: _____ Address: _____

Rem. Benefits: _____ Rem. Deduct: _____

What prompted you to contact our office for an appointment? _____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Do you use the following?

Toothbrush Y N How often? _____

Dental Floss Y N How often? _____

Other oral hygiene device? Y N What and how often? _____

Do you have or have you ever had any of the following?

___ Orthodontic treatment ___ Teeth sensitive to hot, cold, sweet

____Clicking/ popping jaw ____ Teeth sensitive to chewing

___ Clenching or grinding ___ Bleeding or sore gums

____ Loose teeth ____ Unpleasant taste or bad breath

Are you happy with the appearance of your teeth? Y N