Welcome!

Name: ____

Spouses' name: ____

Address: ____

Date of Birth: ______________________ Telephone #: ______________________

Employer: _____________________________ Employer/additional telephone #: ____________________

Additional Address: ____Email _________________________

Dental History

Reason for today's visit: ____

Previous Dentist: ____________________ Last Visit: ______________ Last Cleaning: ________________

How many times a day do you brush your teeth? ___________ Do your gums bleed? _________

Do you have any of the following? (Please mark with a circle)

Sensitivity • Loose teeth • Broken teeth • Pain in the jaw.

Have you had a bad dental experience? ____

____

Have you have orthodontic work, gum treatments, root Canals, oral surgery, crowns, or implants? _______________

Are you happy with your smile? _________ If not, please explain: ________________________________

____

Are you interested in replacing missing teeth? ____

Do you have any questions for the doctor? ____

____

Did someone refer you? _______ Whom? ____

For Patients with Insurance:

Name of Insurance________________________________ Phone # insurance_____________________________

Insurance Address____

Plan: _______________ Group: _______________ Policy: ______________________

Name of Insured: ________________________________Relation:_____________

Date of Birth of insured: ____

Name of Employer of Insured: ____

Patient/Guardian Signature:____ Date:________________________