

Patient information

Name _____ date of birth _____

Address _____

City _____ Zip code _____

Phone Number _____ Email _____

Male ____ Female ____

Emergency Contact _____ Phone Number _____

Relationship _____

How did you hear about the practice _____

Dental insurance

Insurance Company _____ Phone Number _____

Subscriber ID _____ Group Number _____

Name of subscriber _____ Date of birth _____

Dental history

Reason for today's visit _____

Date of last dental check up _____

Please check if you have any of the following conditions:

Bad breath ____ Loose or broken teeth ____

Bleeding gums ____ Sensitivity when biting or chewing ____

Pain when flossing ____ Sensitivity to cold or hot ____

Mouth sores ____ Clicking or popping jaw ____

Teeth grinding ____ Missing teeth ____

Is there anything about the appearance or function of your teeth you would like addressed?
