W E L C O M E

Patient Information

Date_____ **Home Phone** (_____)_____ **Cell Phone** (_____)_____ ☐ ok to receive text

Name_____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address_____E-mail_____ ☐ ok to receive emails

City_____State_____Zip_____

Sex ☐ M ☐ F Age_____Birth date_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Preferred Name _____ ☐ Separate ☐ Divorced ☐ Partnered for_____years

Patient Employer/School_____Occupation _____Work Ph.( )_____

How did you hear about us? _____ What do you do in your spare time?_____

In case of emergency who should be notify? _____Phone ( ) _____

Primary Insurance/Account Responsibility:

Person Responsible for Account ☐ Same As Above _____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate _____ Soc. Sec. #_____

Address (if different from patient's)_____Phone (_____)_____

City_____State_____Zip_____

Person Responsible Employer_____Occupation_____

Insurance Company_____Group # _____Subscriber #_____

Acquaintance Questions: (Please Circle One)

1. My mouth is A. Pain free B. Slightly sensitive C. In pain

2. I am A. Completely satisfied with the appearance of my mouth B. Slightily satisfied C. Dissatisfied

3. I A. Have set goals for my oral health B. Would like to C. Never set goals concerning my dental health

4. I think my present state of dental health is A. Excellent B. Good C. Poor

Rank in the order of importance: 1 being most important / **5** being least important

___ appointment availability ___ payment flexibility ___ pain free ___ friendliness of office ___ advanced technology

Dental History:

Reason for Today's Visit _____Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Check (√) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss?_____How often do you brush?_____

Do you currently have a Snoring problem that you are aware of? ☐Yes ☐No