# Patient Information

Patient's Name _____ Today's Date _____
Home Address _____
City_____ Zip_____ Res. Tel.#_____ Cell #:_____
Social Security # _____-_____-_____ Date of Birth _____/_____/_____ Age_____ Marital Status S/M/D/W
Your Occupation_____ Employer_____ Bus.Tel# _____
Spouse's Name_____ Date of birth ____/____/____ Social Security # _____-_____-_____
Your spouse's Occupation_____ Employer_____ Bus.Tel# _____
Person to contact in an emergency_____ Relation_____
Res. Tel. #_____ Bus. Tel. #_____ Address_____
Party responsible for account _____ Bus Tel. #_____ Res Tel.#_____
Reason for this visit _____
Whom may we thank for referring you?_____

## HEALTH HISTORY

***For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL***

**Dental History:**

Previous Dentist_____ City_____ How long_____
Date of last visit_____ Date of last dental cleaning _____ Date of last full mouth x-ray _____

1. Why did you leave your last dentist? _____
2. What did you like most about any dentist, or a dental office you have been to? _____
3. What did you like least about any dentist, or dental office that you have been to? _____
4. Are you having any discomfort at this time? ____Yes ____No
5. Have you ever had any serious trouble associated with previous dental treatment? ____Yes ____No
6. Does dental treatment make you nervous? ____Yes ____No
7. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ____Yes ____No

**Check any of the following you have had or currently have:**

___ Mouth discomfort
___ Periodontal Treatment
___ Trenchmouth or Pyorrhea
___ Gum Abscesses
___ Gums Bleed when Brushing
___ Trouble Chewing/Speaking
___ Grind or Clench your teeth
___ Pain, Clicking, Popping in Jaw Joints
___ Orthodontic Treatment
___ Immediate Relatives that have lost all of their Natural Teeth
___ Mouth Odor or Bad Taste
___ Cold Sores or Fever Blisters
___ Other Oral Lesions
___ Bad Dental Experience
___ Loose or Shifting Teeth
___ Bruise Easily
___ Sensitive Teeth (Hot, Cold, Sweets)
___ Fear of Dental Treatment
___ Awake with Sore Jaws
___ Complications with or following previous Dental or Oral Surgical treatment

If you could change one thing about your smile, what would that be?_____
_____

Do you want to keep your teeth? ____ Yes, no matter how much trouble ____ I don't know
____ Yes, if it's not too much trouble ____ I don't know