Responsible Party (if different)

Name of Responsible Party: _____
Last First MI
Social Security: _____ - _____ - _____ Birth Date: _____

Address: _____

Phone (H): _____ (W): _____ (Mobile): _____

OPTIONAL: Insurance Information (to be printed on your claim form as a courtesy)

Policy/Group Number: _____

Place of Employment (if through company) _____

Insurance Company: _____
Ins. Co. Address: _____
Ins. Co. Phone: _____

Dental History (Please circle the answers that apply)

YES NO Have you ever had a severe toothache?
YES NO Have you ever had a broken tooth or filling?
YES NO Have you ever had gum treatment or been told you have a gum problem?
YES NO Have you ever been advised by a doctor to pre-medicate yourself prior to dental treatment due to any existing condition?
YES NO Do you feel that you would require instruction on proper brushing and flossing?
YES NO Are any of your teeth currently sensitive to hot, cold, or biting pressure?
If yes, which? _____
YES NO Do you have any pain, swelling, bleeding associated with your gums?
If yes, which? _____
YES NO Are you having any problems chewing your food?
YES NO Are you having any problems with your jaw joints?
YES NO Are you grinding or clenching your teeth at night or when you feel stress?
YES NO Have you received regular dental care throughout your life?
If not, please explain _____
YES NO Are you nervous or anxious about receiving dental treatment?
YES NO Are you satisfied with the appearance of your teeth?
If not, please explain _____

When was your last dental visit? _____ What was done? _____
Any other comments regarding your dental treatment or history: _____
_____
_____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct.

Signed: _____
Patient/Parent/Guardian Date