PATIENT

Name ____
First Last MI Preferred Name

Address ____
Street

____
City State Zip

Phone ____________________ ____________________ ____________________
Cell Home Work

E-mail ____

How would you prefer to receive appointment reminders? Text E-mail Phone (Please circle)

If you are unavailable, may we leave a message? Y / N (Please circle)

PERSONAL ______________ ____________________ ________________________
Date of Birth Social Security Number Marital Status (S M W D Other)

______________ ____________________ ________________________
Occupation Employer Preferred Pharmacy

DENTAL

Who can we thank for referring you to our office? ____________________________________

When and where was your last dental exam? ____

How often do you brush your teeth? ___________________ Floss? __________________

Do you grind or clench your teeth? Y / N / Not sure Do you have any jaw pain or clicking? Y / N

Have you had orthodontic treatment? Y / N Are you interested in straightening your teeth? Y / N

Have you ever whitened your teeth? Y / N Would you like whiter teeth? Y / N

Are you having any pain or areas of concern that you would like the dentist to evaluate? Y / N

____

Are you happy with your smile? Y / N If not, what don’t you like? _______________

____

Signature ______________________________________ **Date** __________________