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** _____