PATIENT INFORMATION FORM

Name _____

Address _____ Phone _____

City _____ State _____ Zip _____

DOB_____ Social Security # _____ Single ___Married ___Divorced ___ Widowed____

Patient Employed by _____ Occupation _____

Business Address _____ City _____

Business phone _____ Name of Spouse _____

Spouse Employed by _____ Occupation _____

Name of Dentist _____ How long have you been a patient? _____

Reason for this visit _____ Referred by _____

Name of Physician _____ Phone _____

Address of Physician _____

INSURANCE INFORMATION

Insurance Co. Name _____Policy/Group# _____

Ins. Co. Address _____

Insured's Name _____Ins. DOB _____Insured's SS# _____

SECONDARY INSURANCE

Insurance Co. Name _____Policy/Group # _____

Ins. Co. Address _____

Insured's Name _____Ins. DOB _____Insured's SS# _____

For your welfare and our efficiency of diagnosis and treatment, please fill in the following **confidential** form COMPLETELY.

DENTAL HISTORY

Have you been treated for gum disease before?..... ___**YES** ___**NO**

If *YES*, when ? _____ By Whom? _____

Do your gums bleed?..... ___**Occasionally** ___**Often** ___ **Never**

Are you having pain or soreness in your mouth?..... ___**YES** ___**NO**

Do you clench or grind your teeth?..... ___**YES** ___**NO**

Have you or anybody in your family experienced any form of HEART DISEASE ? ___**YES** ___**NO**

Has anybody in your family had gum disease or lost their teeth?..... ___**YES** ___**NO**

If *YES*, who? _____

Have you had a bad experience in a dental office? ..... ___**YES** ___**NO**

If *YES*, what? _____

Do you have any concerns about dental care in our office? ..... ___**YES** ___**NO**

If *YES*, what are they? _____

Are you happy with the way your mouth looks? ..... ___**YES** ___**NO**

If *NO*, what do you not like? _____