PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____ Gender: M F Marital Status: S M

Date of birth: Month_____ Date: _____Year: _____ Age: _____ Insurance: ___Yes ___No

Home Address: _____City: _____State: _____ Zip: _____

Home Phone: (_____) _____Cell Phone: (_____)_____Email:_____

Soc. Sec. #: _____ Emergency Contact: Name:_____ Phone: _____

Patient under guardianship/conservatorship: Person responsible: _____Phone: _____

Do you have a "Durable Power of Attorney" for medical decisions? Yes No Name: _____Phone_____

Employed: _____ Address/city: _____

Work Phone: (_____) _____ Does your employer offer insurance?_____

No. of people in household: _____ Household Family Income: Wages: $_____ Unemployment: $_____Social Sec.: $_____

Public Assistance: $_____ other: $_____ Own a home? _____Total: $ _____

DENTAL HISTORY

	YES	NO
Do your gums bleed when you brush?		
Have you noticed any lumps or sores in your mouth?	YES	NO
Are your teeth sensitive to cold, hot, sweets or pressure?	YES	NO
Have you ever injured your face, jaws or teeth?	YES	NO
Are you happy with the appearance of you teeth?	YES	NO
Are you allergic to any metals or dental materials?	YES	NO
What types of dental treatment you have had?	YES	NO

Orthodontics (braces) Denture Root Canal Implants

Oral Surgery Periodontal treatment TMJ (Jaw) Treatment Fillings

Have you had problems with previous dental treatment? **YES** **NO**

If yes explain:

_____

_____

_____

Do you have regular dental exams? **YES** **NO**

Date Last Dental Exam: _____ Date Last X-rays: _____

Are you a veteran? YES NO