

Medical/Dental History

Date: _____

Patient's Name: _____ Sex: _____ Age: _____ Birthdate: _____

Prefers to be addressed by: _____ Referred by: _____

IF CHILD:
PARENT'S NAME _____
Last First Initial

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RES. _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

MARITAL STATUS: Married Single Divorced
 Separated Widowed

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

METHOD OF PAYMENT: Insurance Credit Card Cash

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

NAME AND TEL. NO. OF SOMEONE NOT LIVING WITH YOU TO
NOTIFY IN CASE OF EMERGENCY _____

DENTAL INSURANCE - 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DRIVERS LICENSE NO. _____

DENTAL INSURANCE - 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DRIVERS LICENSE NO. _____

DENTAL HISTORY

Last Dental Visit: _____ Where?: _____ With Whom?: _____

1. Have there been any injuries to the face, mouth or teeth? YES NO
2. Have you had or do you presently have any of the following habits?
 NO Thumb or finger sucking Lip Biting Snoring
 Grinding of teeth at night Mouth breathing
3. Have you been informed of any missing or extra permanent teeth? YES NO
4. Are you aware of sores, lumps or irritated areas in the mouth? YES NO
5. Have you ever been treated for:
If so, by whom?: NO Bad Bite TMJ Periodontal disease
When?
6. Do you have any speech problems? YES NO
7. Are you frightened or anxious about dental treatment? YES NO
8. Are you concerned about the appearance of your teeth? YES NO
9. Is there anything you would like to change about your smile?
If so, what: YES NO
10. What aspect of dental treatment are you most concerned with? Quality Cost Discomfort Time
11. Reason for consultation (chief concern): _____

