

PATIENT HEALTH RECORD

In order to help us provide proper dental services to you, please complete this form to the best of your ability. There are TWO SIDES to be completed. Please print.

Demographic Information

Full Name _____
I prefer to be called _____
Street Address _____
City _____ State _____ Zip _____
Date of Birth ____/____/____
Sex _____ Height _____ Weight _____
Home Phone # _____
Cell Phone # _____
Work Phone # _____
Social Security # _____

Date ____/____/____
Email Address _____
Employer _____
Employer's Address _____
City _____ State _____ Zip _____
Marital Status _____
Spouse's Name (if applicable) _____
Name of Closest Relative _____
Relationship _____
Relative's Phone # _____

If Patient is a Minor

Name of Mother _____
Phone # _____

Name of Father _____
Phone # _____

Dental Insurance

Do you have dental insurance? Y N

If yes, please complete the following:

Name of Policy Holder _____
Name of Insurance Co. _____

ID # _____
Group # _____

Dental History

Reason for Today's Visit _____

Approximate date of last visit _____

Previous dentist _____

Reason you left that dentist _____

How often do you brush your teeth? _____

Toothbrush texture.....SOFT MEDIUM HARD

How often do you floss? _____

Do your gums bleed when you floss?.....Y N

Have you been treated for gum disease?.....Y N

Are your teeth sensitive?.....Y N

Are you satisfied with your smile?.....Y N

If no, what would you change? _____

Do you grind your teeth?.....Y N

Do you snore?.....Y N

Do you have TMJ problems?.....Y N

Do you experience frequent headaches?.....Y N

Are you anxious about dental treatment?.....Y N

Would you like your breath to be fresher?....Y N

Would you like your teeth to be whiter?.....Y N

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