FAMILY CARE DENTISTRY

PATIENT INFORMATION

We appreciate the confidence you have placed with us to provide Dental Care to you. All information on this chart is necessary for our records and is strictly confidential.

PATIENT NAME: FIRST_____ MI_____LAST_____DOB_____

ADDRESS_____STATE_____ZIP_____

HOME PHONE (____)_____ WORK PHONE(____)_____ SOCIAL SECURITY #_____-_____-_____

CELL PHONE (____)_____ EMPLOYER _____

POLICY HOLDER INFORMATION

NAME _____ SSN_____INSURANCE COMPANY _____

EMERGENCY CONTACT_____ PHONE _____

PLEASE LET US KNOW HOW YOU HEARD ABOUT US.

❑ FRIEND/RELATIVE_____ ❑ SIGNAGE ❑ ADVERTISING

❑ INSURANCE COMPANY ❑ YELLOW PAGES

❑ OTHER_____

DENTAL HEALTH INFORMATION

Thank you for providing us with important information that will help us serve you better.

	YES	NO
Are you having any discomfort?	❑	❑
Any sensitivity to hot, cold, sweets, chewing?	❑	❑
Does dental treatment make you nervous?	❑	❑

Have you experienced any of the following problems:

Bleeding gums	❑	❑
Bad breath	❑	❑
Soreness in jaw joint	❑	❑
Grinding of teeth	❑	❑
Snoring	❑	❑

On a scale of 1 to 10 with 10 being the highest rating: (circle one)

How important is your health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

Do you think your dental health effects your overall health?	❑	❑
Do you think it's important to have your teeth cleaned at least every six months?	❑	❑

	YES	NO
Is the brightness of your teeth important to you?	❑	❑
Do you smoke or use tobacco in any form?	❑	❑
Do you drink coffee or tea?	❑	❑

If I could change my smile I would make my teeth:

Whiter	❑	❑
Straighter	❑	❑
Close space	❑	❑
Replace black mercury filling with tooth colored restorations	❑	❑
Repair chipped teeth	❑	❑
Repair missing teeth	❑	❑
Less gum showing	❑	❑
Replace old crowns or caps that don't match	❑	❑
Do you prefer to save your teeth?	❑	❑
Have you ever had a special coating applied to your back teeth to protect from tooth decay?	❑	❑
Do you take a fluoride supplement?	❑	❑

When was the last time you had an oral cancer exam?

_____

Date of last cleaning: _____

If there were a way to whiten your teeth for a very reasonable investment, would you be interested? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____