Patient Information Form

Patient Information

Patient Name (Last, First, Middle) _____

Address:_____ City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ SS#:_____-- _____ -- _____

DOB: _____ Sex: M/F _____ Marital Status: Married Single Divorced Widow

Spouse's Name: (Last, First, Middle) _____

Emergency Contact

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Dental Information

Reason for visit today: _____

Date of Last Exam: _____ Date of Last X-Ray: _____

Are you currently experiencing dental pain or discomfort?	☐Yes ☐ No
Do your gums bleed when you brush or floss?	☐Yes ☐ No
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐Yes ☐ No
Is your mouth dry?	☐Yes ☐ No
Have you had any periodontal (gum) treatment?	☐Yes ☐ No
Have you ever had any problems associated with previous dental treatment?	☐Yes ☐ No
Is your home water supply fluoridated?	☐Yes ☐ No
Do you drink bottled or filtered water?	☐Yes ☐ No
Do you have earaches or neck pain?	☐Yes ☐ No
Do you have any clicking, popping, or discomfort in the jaw?	☐Yes ☐ No
Do you brux or grind your teeth?	☐Yes ☐ No
Do you have dentures or partials?	☐Yes ☐ No
Do you participate in active recreational activities and/or contact sports?	☐Yes ☐ No
Have you ever had a serious injury to your head or mouth?	☐Yes ☐ No

How do you feel about your SMILE: _____

Patient/Parent/Legal Guardian Signature: _____ Date_____

Relationship to Patient: _____ Phone: _____