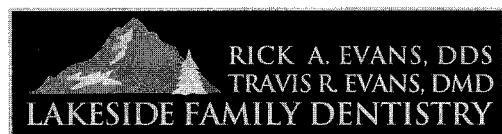


Patient Health Record

We welcome you to our office!

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions.



Member ADA, ODA, AGD

If this appointment is for you start here

Date _____
 Name _____
 Address _____
 Home Phone # _____
 Cell Phone # _____
 Best # to Call _____
 Email Address _____
 Birthdate _____
 Married Single Divorced Widowed

If this appointment is for your child start here

Date _____
 Name _____
 Address _____
 Home Phone # _____
 Birthdate _____ Age _____
 Grade _____
 School _____
If your child's address is different from yours, please fill in the top box also.

Primary Dental Insurance

Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone #: _____
 Insurance ID #: _____
 Insurance Group # _____
 Insured's Name: _____ Relation: _____
 Insured's Birthday: ___ / ___ / ___ Insured's SS#: _____
 Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____
 Insurance Co. Address: _____
 Insurance Co. Phone #: _____
 Insurance ID #: _____
 Insurance Group #: _____
 Insured's Name: _____ Relation: _____
 Insured's Birthday: ___ / ___ / ___ Insured's SS#: _____
 Insured's Employer: _____

Account Information

Person Responsible for Account _____
 Your Occupation _____
 Your Employer _____
 Your Employer Phone # _____
 Your Driver's License # _____
 Bank _____
 Your Spouse _____
 Spouse's Employer _____
 Spouse's Employer Phone # _____

Getting to know you

What are your hobbies and interests? _____
 Where were you raised? _____
 Number of children? _____
 Are any of your relatives a patient of our office? _____
 Referred to us by _____
 Person to contact for emergency _____
 Phone _____
 How do you wish to be addressed by our staff? _____

Please fill out the Medical History on the other side.

Dental History

Reason for today's visit _____ Date last Dental visit _____ What was done then? _____
 How often do you brush your teeth? _____ Floss? _____ What texture brush do you use? _____
 Previous Dentist? _____ Reason for leaving dentist? _____

Do any of the following conditions apply to you? (circle yes or no)

Bleeding gums?	yes no	Teeth straightened?	yes no
Food impaction?	yes no	Sounds in ears when chewing?	yes no
Swelling or lump in mouth?	yes no	Loose teeth?	yes no
Clenching or grinding teeth?	yes no	Avoid Brushing any	
Unpleasant taste?	yes no	area of your mouth?	yes no
Tired Jaws?	yes no	What area? _____	
Gag easily?	yes no	I would like my teeth whiter	yes no
Complications from extractions?	yes no	I prefer tooth colored fillings	yes no
Gum Treatments?	yes no	Use Fluoride supplements?	yes no

Do your teeth hurt when in contact with:

Hot foods or liquids?	yes no
Cold food or liquids?	yes no
Sweet foods or liquids?	yes no
Bite or pressure sensitivity?	yes no

Are you satisfied with the appearance of your teeth?

Any serious problems with dental treatment?	yes no
Do you have any mouth pain?	yes no