Welcome to Brea Family Dental Center

Patient's Last Name_____ First_____ Nickname_____

Home Address_____ City&zip_____

Birthdate_____ Social Security #_____ Parent's Soc Sec #_____

Home Phone_____ Work Phone_____ Cell Phone_____ Email address_____

Employer_____ Occupation_____ Years w/ firm_____

Employer's Address_____ City_____

Check appropriate space: ___minor ___single ___married ___divorced ___widowed

Spouse's or Parent's name_____ Employer_____

Spouse's Employer Address_____ City_____ Phone #_____

If patient is a student, name of school _____

Person to contact in case of an emergency_____ Phone #_____

Physician _____ Phone #_____ Last visit_____

Former Dentist_____ Phone #_____ Last visit_____

Driver's License # _____ Who is financially responsible? _____

Who may we thank for referring you? _____

Are you covered by dental insurance? _____ Company_____

Subscriber's SS# or ID#_____ Birthday_____

Is your spouse covered? _____ Company_____

Medical and Dental History

1. Are you having pain or discomfort at this time? . . . . . YES NO
2. Have you ever had a bad experience in the dental office? . . . . . YES NO
3. Do you feel very nervous about having dental treatment? . . . . . YES NO
4. Do your gums bleed when brushing? Flossing? . . . . . YES NO
5. Have you ever had periodontal treatment? . . . . . YES NO
6. Do you clench or grind your teeth? . . . . . YES NO
7. Do you have frequent headaches or neck aches? . . . . . YES NO
8. Have you had any surgery in the past 2 years? . . . . . YES NO
9. Are you taking any prescription or over the counter medicine? . . . . . YES NO

   Are you being treated for osteoporosis? . . . . . YES NO

   Please list all meds _____