PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____ ☐ Male ☐ Female

DOB:_____ SS #:_____ Email:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____ Address:_____

Emergency Contact: _____ Relationship:_____ Phone:_____

RESPONSIBLE PARTY INFORMATION

☐ Self *(Skip to Insurance Information)*

Full Name:_____ Relationship:_____ DOB:_____ SS#:_____

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

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____ Address:_____

INSURANCE INFORMATION

Do you have dental insurance? ☐ YES (*Complete this section*) ☐ NO *(Skip to Dental History Information)*

Policy Holder Name: _____ DOB: _____ Relationship to Patient:_____

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

Employer_____ Employer Phone #_____

Insurance Company:_____ Group #:_____ SS# or Insurance ID#:_____

(*NOTE: A valid ID# or SS# is required in order for us to file your insurance claim.*)

DENTAL HISTORY INFORMATION

Reason for today's visit:_____

_____

Have you ever had or currently have:

Bleeding when you brush	☐ Yes	☐ No
Gum pain or swelling	☐ Yes	☐ No
Pain in jaw or ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Difficulty chewing	☐ Yes	☐ No
TMJ treatment	☐ Yes	☐ No
Grinding or clenching	☐ Yes	☐ No
Clicking or popping noise in your jaw	☐ Yes	☐ No
Food getting stuck in your teeth	☐ Yes	☐ No
Loose adult teeth	☐ Yes	☐ No

Do you have frequent headaches	☐ Yes	☐ No
Do you snore or mouth breathe	☐ Yes	☐ No
Do you have bad breath	☐ Yes	☐ No
Are you sensitive to hot, cold or sweets	☐ Yes	☐ No

On a scale of 1—10 (10 being most important), how important is your dental health to you: _____

If you could change something about your smile, what would it be:

☐ Whiter ☐ Straighter
☐ Closed spaces ☐ Replace missing teeth
☐ Repair broken teeth ☐ Replace silver fillings
☐ New denture/partial ☐ Have a more stable denture/partial
☐ Other:_____

_____

THANK YOU FOR HELPING US HELP OTHERS BY ANSWERING THE FOLLOWING QUESTIONS:

HOW DID YOU HEAR ABOUT OUR OFFICE?

Please Circle One:

Postcard/Letter *Williamsburg Dentist Magazine* *Mini Implant Mailer* *Internet* *Facebook* *Patient/Family* *Brochure* *Other*

What made you call us? *(Please be specific)*_____

If referred by a *PATIENT*, please let us know *Who Can We Thank:* *Name:* _____

What did they say about us? _____

If you found us on the *INTERNET*, *What did you search for*? _____

If *OTHER*, please explain: _____

WE WANT TO KNOW YOUR THOUGHTS?

What do you like about dentistry? _____

What scares you about dentistry? _____

How would you describe the perfect dentist? _____

What is important to you when choosing a dentist? _____

What days and times are most convenient for you to visit the dentist? _____

The highest compliment you can give us is the referral of your family and friends!

Receive a $25 Visa, Target or Amazon gift card for each new patient you refer to our office.