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Cosmetic Reconstructive Dentistry

PATIENT HISTORY AND ACQUAINTANCE FORM
This Information is Important for Our Records and Your Health

Today's Date _____ Patients Name _____ Email: _____

SSN _____ Date of Birth _____ Age _____

Residence Address _____ City _____ State _____ Zip _____

Residence Phone _____ Work Phone _____ Cell Phone _____

Employed By _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Referred By _____ Email: _____

Do you have any dental insurance? Y N Name of insurance company _____

Address of insurance company _____ Group No. _____

Name if insured party _____ Who will pay this account? _____

Marital Status Single Married Widowed Divorced Separated

NAME IN FULL OF YOUR (HUSBAND, WIFE, PARENT) _____ Date of Birth _____

Employed by _____ Employer's Address _____

Email : _____ Occupation: _____

SSN _____ Physician's name _____ Phone Number _____

In case of emergency, who should we notify? _____ Phone Number _____

	YES	NO
How long since your last dental visit? _____		
Do your gums bleed at all upon brushing/flossing? Y N _____		
Are you having any dental problems presently? If so, describe _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in cosmetic dentistry (bleaching, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontics (braces)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you brush your teeth regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you floss your teeth regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth when you are nervous or sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws click or pop when you chew?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other information we should know about your health or previous dental visits? If so, explain _____	<input type="checkbox"/>	<input type="checkbox"/>
Have I ever treated any of your friends or family? If so, name? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for TMJ (jaw) problems?	<input type="checkbox"/>	<input type="checkbox"/>

I AUTHORIZE THE RELEASE OF ALL DENTAL INFORMATION ABOUT ME OR MY MINOR CHILDREN TO PHYSICIANS, HOSPITALS, INSURANCE COMPANIES AND DENTISTS.

SIGNATURE OF PATIENT (IF MINOR, PARENT SIGNS) _____ DATE _____
TURN OVER AND CONTINUE.....

