Patient Information

Patient's Name ____ Today's Date ___________________________
Home Address ____
City_________________________ Zip_____________ Res. Tel.# ____________________DL #________________
Social Security # _____-_____-_____ Date of Birth _____/_____/_____ Age____________ Marital Status S/M/D/W
Your Occupation____________________Employer__________________Bus.Tel# _____________Cell #___________
Spouse's Name____ Social Security # _____-_____-_____
Your spouse's Date of Birth____/____/____Employer___________________Bus.Tel# ____________Cell#___________
Person to contact in an emergency____ Relation__________________
Res. Tel. # __________________ Bus. Tel. #________________ Address______________________________________
Party responsible for account ___________________________ Res.Tel. #________________Cell Tel.# _____________
Reason for this visit ____
Whom may we thank for referring you? Patient **Name:________________________Google:____________________**
Internet Brenham Dentist:____________Website:______________Delta Dental:___________ Other:____________

DENTAL HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL

Dental History:

Previous Dentist_______________________________ City_______________________ How long___________________
Date of last visit______________ Date of last dental cleaning___________ Date of last full mouth x-ray ______________

1. Why did you leave your last dentist?____
2. What did you like most about any dentist, or a dental office you have been to?___________________________________
3. What did you like least about any dentist, or dental office that you have been to?________________________________

Check any of the following you have had or currently have:

___ Mouth discomfort
___ Have Lightened Your Teeth Before
___ Grind or Clench your teeth (Daytime or Nighttime)
___ Pain, Clicking, Popping in Jaw Joints
___ Awake with Sore Jaws
___ Periodontal Treatment
___ Gum Abscesses
___ Gums Bleed when Brushing
___ Mouth Odor or Bad Taste
___ Bruise Easily
___ Loose or Shifting Teeth
___ Trouble Chewing/Speaking
___ Fear of Dental Treatment
___ Immediate Relatives that have lost all of their Natural Teeth
___ Orthodontic Treatment
___ Sensitive Teeth (Hot, Cold, Sweets)
___ Complications with or following previous Dental or Oral Surgical treatment
___ Cold Sores or Fever Blisters

If you could change one thing about your smile, what would that be?____
____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? Y N

Do you want to keep your teeth? ____ Yes, no matter how much trouble ____ I don't know
____ Yes, if it's not too much trouble ____ I don't care