

Date _____



815.786.9811
Fax 815.786.6221

Mr., Mrs., Ms., Dr. Last Name _____ First _____ M.I. _____

Preferred name _____ Male, Female Birthdate _____

Soc. Sec. # _____ E-mail _____

Physical Address _____ Zip _____

Mailing Address (if different) _____ Zip _____

Home Tel. _____ Cell _____ Preferred number; Home Cell

Employer Bus. Tel. _____ Personal Bus. Tel. _____ Preferred number; Main Personal

In case of emergency, please contact _____

Have you ever been a patient of our practice? Y N

Whom may we thank for referring you to our practice? Another patient who is Friend, or Relative, Yellow Pages, Newspaper, Other,

Name of person referring you to our practice: _____

INSURANCE INFORMATION Do you belong to a PPO or HMO?

Insurance Company Name _____

Employed: Full Time, Part Time, Retired, Not employed, Married, Divorced, Legally Separated, Widow, Single,

Student: Full Time, Part Time, Not currently, School Name/Address _____

DENTAL INFORMATION

Reason for today's visit: Exam Consultation Emergency Are you in pain? Y N, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- Discomfort, clicking, or popping in jaw
- Red, swollen, or bleeding gums
- Teeth grinding / clenching
- Toothache
- A removable dental appliance
- Burning tongue / lips
- Loose / shifting teeth
- Ringing in ears
- Broken / chipped tooth
- Swelling / lumps in mouth
- Gum disease
- Bad breath
- Prolonged bleeding from an injury/extraction
- Food caught between teeth
- Blisters/sores in or around the mouth
- Recent infections or sore throat
- Other: My teeth are sensitive to: Hot, Cold, Sweets, Biting

Last Dental Exam? _____ Last dental x-rays? _____

Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like to change your smile? Y N