INSURANCE

Policy Holder: ______________________________________ Birth Date: ____/___/______

Soc. Sec. #: _____-____-_______ Relationship to Patient: _________________________________

Employer: __________________________ Insurance Company: _____________________________

Subscriber I.D. #: __________________________ Group #: _________________________________

DENTAL HISTORY

Former Dentist: _______________________________ City/ State: ______________________________

Date of last dental visit: ________________________ Date of Last X-Rays: _______________________

How often do you floss? ________________________ How often do you brush? ____________________

Why did you leave your previous dentist? ____

Reason for your visit today: ____

Type of tooth brush? ☐ Soft ☐ Medium ☐ Hard ☐ Electric Oral Irrigator? ☐ Yes ☐ No

Please check all that apply:

☐ Loose teeth/ Fillings ☐ Bad Breath ☐ Grinding Teeth ☐ Bleeding Gums

☐ Orthodontic Treatment ☐ Frequent Headaches ☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking/ Pain

☐ Periodontal Treatment ☐ Tooth Pain ☐ Sleep Apnea ☐ Jaw, Head, or Neck Injuries

Sensitivity To: ☐ Cold ☐ Hot ☐ Sweets ☐ When Biting ☐ None

Do you have or have had any of the following:

☐ Dentures ☐ Partial Dentures ☐ Braces ☐ Invisalign ☐ Orthodontic Retainer