Center for Implant & Esthetic Dentistry

Welcome *Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us-we will be happy to help.*

Patient Information *(confidential)*

Name _____ Birthday ____ / ____ / ____ ☐ Male ☐ Female
(Last) (first) (MI)

Address_____City_____State_____Zip_____

Home Phone ( ) __ __ __-__ __ __ __ Work Phone ( ) __ __ __-__ __ __ __ Cell Phone ( ) __ __ __-__ __ __ __

E-mail: _____

I prefer to receive appointment & recall reminders via: ☐ E-mail ☐ Text ☐ Phone call

Check Appropriate Box ☐ Married ☐ Single

Person to Contact in Case of Emergency _____ Phone Number ( ) __ __ __-__ __ __ __

Name of the Person Responsible for this Account _____ Relationship to Patient_____

Whom may we thank for your referral: _____

Dental History

Reason for this visit ……

Previous Dentist …….. Date Last treated? ……..……

Are you having pain at this time? *Location of pain & Describe* …… Yes No

Have you ever had:

- Orthodontic Treatment? …… Yes No
- Oral Surgery? …… Yes No
- Periodontal treatment? …… Yes No
- Your teeth ground or your bite adjusted? …… Yes No
- Worn a bite plane or other appliance? …… Yes No

Have you noticed any loosening of your teeth? …… Yes No

Does food tend to become caught between your teeth? …… Yes No

Do you suffer from pain &/or swelling of your gums? …… Yes No

Do your gums often bleed when you brush your teeth? …… Yes No

History of gum disease in your family …… Yes No

Problems in the jaw. Have you ever experienced:

- Clicking of the jaw? …… Yes No
- Pain (Joint, Ear, Side of Face)? …… Yes No
- Difficulty in opening & closing? …… Yes No
- Difficulty in chewing? …… Yes No

Habits. Do you:

- Clench or grind your teeth while awake or sleep? …… Yes No
- Bite your lips & cheeks regularly? …… Yes No
- Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)? …… Yes No
- Mouth breath while awake or asleep? …… Yes No

Do you feel nervous about having dental treatment? …… Yes No

Have you ever had an unpleasant experience in a dental office? …… Yes No

Has a dentist ever behaved badly toward you? …… Yes No

Is it important to you to keep your teeth? …… Yes No

Are you satisfied with the appearance of your teeth? …… Yes No

Anything else we should know about your dental history? *Explain* …… Yes No

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Over Please