Welcome to Our Practice!

Form 401D

Today's Date:_____ Patient # _____

PATIENT INFORMATION

☐ Mr. ☐ Ms ☐ Miss ☐ Mrs. ☐ Dr.

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS # _____

Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Dependent

RESPONSIBLE PARTY
IF OTHER THAN PATIENT

Relationship to patient _____

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS #_____

Birth Date _____ Age _____

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

EMPLOYMENT INFORMATION

Employer _____

Work Phone _____

Occupation _____

How Long at Current Job? _____

INSURANCE

Insurance Company _____

Address _____

City/State/Zip _____

Phone # _____

Insured's Employer _____

Insured's Name _____

Relationship to Patient _____

Insured's SS # or Membership # _____

POLICY / GROUP NUMBER _____

PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:

TEETH:

☐ Broken or Chipped
☐ Cracked
☐ Decay
☐ Difficulty Chewing
☐ Discolored
☐ Food Trap Areas
☐ Grinding or Clenching
☐ Loose or Missing Filling
☐ Loose Tooth or Teeth
☐ Missing Tooth or Teeth
☐ Mouth Sores
☐ Sensitive to Temperature Changes
☐ Sensitive to Sweets
☐ Tooth Pain

GUMS:

☐ Bleeding
☐ Pimple or Bump
☐ Sore or Sensitive

JAW / FACIAL PAIN PROBLEMS

☐ Facial Pain
☐ Frequent Headaches
☐ Jaw Clicks
☐ Jaw Pain
☐ Pain in Cheeks or Temples

OTHER CONCERNS OR REASONS FOR VISIT:

_____

_____

☐ Here for a Periodic Examination. No specific Known Dentral Problems.

PAST DENTAL HISTORY:

Last Dental Visit _____

Dental Visit Frequency Ever:

_____ Months _____ Years _____ As Needed

☐ Have Tooth Replacements such as Dentures, Partials, Bridges or Implants?

Other: _____