Dental History

Reason for Your First Visit with Us ______________________________
Former Dentist's Name ______________________
Address ____

Please Check All That Apply

Bleeding Gums? ___	Brush Daily? ___	Missing Teeth? __	Bad Taste?__
Sensitive Teeth? ___	Floss Daily? ___	Clenching or Grinding? ___	Bad Odor?__
Pain in your Teeth? ___	Gum Surgery? __	Joint or Muscle Pain? ___	Crooked Teeth?__

Are you happy with the apperance of your teeth? ___Yes ___No
Are you interested in Cosmetic Dentistry? ___Yes ___No
Have you ever had a Bad Experience at the Dentist? ___Yes ___No
If you have missing teeth, would you like to have them replaced? ___Yes ___No
Have you ever had any teeth replaced with Caps or Partial Dentures? ___Yes ___No
What would you change about your teeth? ______________________________
Would you like to have a better smile? ___Yes ___No
Are you interested in Complete Dental Care? ___Yes ___No
Anything you would like to add that you feel we should know? ______________________________
____

Insurance Information

Primary Insurance
Dental Insurance ___Yes ___No Effective Date _________
Insurance Company ________________________________
Address ____
Insured's Name ________________________________
Group No. _________________________ Contract No. ___________________

Secondary Insurance
Insurance Company ____________________________________
Address ____
Insured's Name ____
Group No. _________________________ Contract No. _________________

Do you have Medical Insurance? ___Yes ___No
Do you understand how your Dental Insurance Coverage works? ___Yes ___No
Do you have your Dental Insurance booklet or information? ___Yes ___No

Signature ____ *Date* ________________________

Reviewed __________ *Date* ______________
Reviewed __________ *Date* ______________
Reviewed __________ *Date* ______________