Thomas family dental associates

## Patient Information

*Name: Last, First, MI:* _____ *Date of Birth:* _____

*Social Security Number:* _____ *Drivers License Number:* _____

*Gender:* ❑ Male ❑ Female *Family Status (insurance purposes):* ❑ Single ❑ Married ❑ Divorced

*Student Status:* ❑ Student ❑ Non Student

Address: _____

City/State/Zip: _____

Home Phone: _____ Email: _____

Mobile Phone: _____ May we send appointment reminders to your Email? Y/N

Work Phone: _____ May we send appointment reminders to your mobile via Text? Y/N

Emergency Contact: _____ Emergency Phone #: _____

## Dental History

How did you hear about our Office? _____

How long has it been since your last visit to the dentist? _____

Why are you changing dentists? _____

Name of previous dentist: _____

Reason for Today's Visit: ❑ Check up ❑ Cosmetic Concern ❑ Pain / Discomfort ❑ Other: _____

| | | |
|---|---|---|
| Have you ever had a bad experience at the Dentist? | ❑ Yes | ❑ No |
| Have you had any complications following dental treatment? | ❑ Yes | ❑ No |
| Have you had an unfavorable reaction to dental anesthetic? | ❑ Yes | ❑ No |
| Does dental treatment make you nervous? | ❑ Yes | ❑ No |
| Are your teeth sensitive to hot/cold? | ❑ Yes | ❑ No |
| Do your gums bleed when you brush or floss? | ❑ Yes | ❑ No |
| Do you clench or grind your teeth? | ❑ Yes | ❑ No |
| Are you aware of sores or irritated areas in the mouth? | ❑ Yes | ❑ No |
| Have you ever been treated for Periodontal Disease? | ❑ Yes | ❑ No |

How often do you brush? _____

How often do you floss? _____

Do you like your smile? _____

If you could change your smile, what would you like to change?

❑ Change the color of my teeth ❑ Change the shape of my teeth ❑ Nothing - I am happy with my smile

❑ Change the position/alignment ❑ Restore worn/broken teeth ❑ Other

I am interested in:

❑ Routine, Preventive Care ❑ Replacement of missing teeth ❑ Teeth Whitening

❑ Teeth Straightening ❑ Other

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about.

Patient/Guardian Signature Date