WELCOME

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be glad to help.

(Please print) **DATE:_____**

NAME:_____ **BIRTHDAY:_____**

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

SEX:FEMALE/MALE **SOCIAL SECURITY #:_____**

HOME PHONE:_____ CELL PHONE:_____

EMAIL:_____ **DO YOU PREFER: TEXT/CALL CELL/CALL HOME**

ARE YOU (CIRCLE ONE): MARRIED SINGLE MINOR

EMERGENCY CONTACT:_____ RELATION/PHONE:_____

DENTAL HISTORY

FORMER DENTIST:_____ PHONE#:_____

DATE OF LAST XRAY:_____ DATE OF LAST DENTAL VISIT:_____

PLEASE CIRCLE ALL THAT APPLY

BAD BREATH	**LOOSE TEETH/BROKEN FILLINGS**	**SENSITIVITY TO SWEETS**	**TOOTH PAIN**
BLEEDING GUMS	**JAW, HEAD, NECK INJURIES**	**SENSITIVITY TO BITIN**	**LIP OR CHEEK BITING**
PAIN AROUND EAR	**BLISTERS ON LIPS/GUMS**	**FREQUENT HEADACHES**	**SENSITIVITY TO HEAT**
FINGERNAIL BITING	**JAW DIFFICULTY: CLICKING/PAIN**	**GRINDING TEETH**	**SENSITIVITY TO COLD**

I hereby authorize and request the performance of dental services for myself and my dependents and further the performance of whatever procedure the judgment of the named Doctor may consider necessary during the performance of any operation. In addition, I also authorize the administration of whatever anesthetics or analgesics which the Doctor deems advisable during the rendering of care. I also authorize any pictures be taken when necessary. (Initials)_____