Name (First/Last): _____ **Date of Birth** (mm/dd/yy):___/___/_____
Preferred name/Nickname: _____ **Gender**: ____Male ____Female
SS #: _____

NEW PATIENT LOG INFORMATION 2014

Please fill in blanks, select checkboxes with ☑ or ☒ on both sides of the paper, Thanks!

Address: _____
City: _____ **Zip:** _____
Phone #: (H) _____ (W): _____
cell phone carrier: _____ (C): _____

Can your cell phone receive text messages(*for appointment confirmation****)?*** ☐ Yes ☐ No
Email (for appointment confirmation): _____

Dental Insurance Carrier: _____ **ID #**: _____
Responsible Party/Policy holder: _____
2nd Dental Insurance Carrier: _____ **ID #**: _____
Responsible Party/Policy holder: _____

Previous dentist's name: _____ **city**: _____
Last date of dental visit (mm/yr): X-rays: ____/_____ Exam: _____/ _____
Cleaning: ____/ ____ ☐ Don't remember
Other(s): _____

Are your teeth sensitive to hot, cold, sweet, sour or pressure? ☐ Yes ☐ No
Are you happy with your teeth's color? ☐ Yes ☐ No
Do you grind or clench your teeth? ☐ Yes ☐ No
Do you wear any removable dental appliance? ☐ Yes ☐ No
Mouth/night guards (☐*Yes*/☐*No*) *Bleaching trays* (☐*Yes*/☐*No*)
Partials/full dentures (☐*Yes*/☐*No*) *Ortho retainers* (☐*Yes*/☐*No*)
How old is the appliance? _____
Do you have any loose tooth / teeth? ☐ Yes ☐ No
Location: ☐ *upper left* ☐ *upper right* ☐ *lower left* ☐ *lower right*
Are you having toothache? ☐ Yes ☐ No
Location: ☐ *upper left* ☐ *upper right* ☐ *lower left* ☐ *lower right*
How long has it been? _____

I have read and answered the above questions to the best of my knowledge. I will notify the office of any changes in a timely manner.

Patient's Signature: _____ **Date: ___ /____ / 2014**

Legal Guardian's Signature: _____ **Relation: _____/_____**

(Office use only: Checked by: _____ Date: ___/____/2014 Entered by: _____ Date: ___/____/ 2014)