Great Lakes Family Dentistry

Exceptional Care for Exceptional People

About You

Today's Date: ____/____/____ male female

Patients Name: _____ _____
first *last* *mi*

What do you prefer to be called: _____

Birth Date: ____/____/____ Age:____ SS# _____

Home Phone: _____ Cell: _____

Work : _____ Other: _____

Address: _____

_____

E-mail Address: _____

Referred By: _____

Employer: _____

Employers Address:

_____

Occupation: _____

Spouses Name: _____

Do you have children: Yes No How Many: _____

Status: single married _____

Dental Information

Do you require medication before a dental appointment? Y N

How would you rate your smile (worst) 1 2 3 4 5 (best)

Reason for today's visit: _____

_____

1. Do your gums bleed when you brush?	Y	N
2. Are your teeth sensitive to cold, hot or pressure?	Y	N
3. Have you had any periodontal (gum) treatment?	Y	N
4. Do you clench or grind your teeth?	Y	N
5. Have you had your wisdom teeth removed?	Y	N
6. Have you ever had orthodontic treatment?	Y	N
7. Do you have headaches, earaches or neck pain?	Y	N
8. Do you wear any removable dental appliance?	Y	N
9. Do your jaws ever ache?	Y	N
10. Any family history periodontal disease?	Y	N
11. Do you have problems with bad breath?	Y	N
12. Have you had any serious/difficult problem associated with any previous dental treatment? If so please explain:	Y	N

_____

_____

How do you feel about the appearance of your teeth_____

_____

Date of last dental exam _____

What was done at that time?_____

_____

Date of last dental x-rays _____

Any current dental problems?_____

_____

Please add anything else that you feel is important: _____

_____

_____

Emergency Information

In case of emergency who would you like us to contact:

Name: _____

Home Phone: _____ Work _____

Cell _____ Relationship _____

Account Information

Primary Dental Insurance

Employer: _____

Insurance Carrier _____

Address: _____
city *state* *zip*

Phone: _____ Group # _____

Policy Holder Name: _____

Policy Holder's SS# _____/____/_____ Relationship _____

Birth Date: ____/_____/_____

Secondary Dental Insurance

Employer: _____

Insurance Carrier_____

Address: _____
city *state* *zip*

Phone: _____ Group # _____

Policy Holder Name: _____

Policy Holder's SS# ____/____/____Relationship _____

Birth Date: ____/____/____