WELCOME

GREEN ACRES FAMILY DENTAL

Patient Information

Patient Name:_____ Date:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐Other_____

Social Security#:_____ Birth Date:_____ Email:_____

Phone(Home):_____ (Work)_____ (Cell)_____

Address:_____

_____

City State Zip

Date of Last Dental Visit:_____ **Reason for Today's Visit**_____

What are the likes and dislikes of your smile?_____
What is one thing you would change about your smile?_____
What are the likes and dislikes of your previous Dentist and Office?_____
What are your cares and concerns?_____
Do you or your spouse have problems snoring?_____
Have you ever had complications following dental treatment?_____

Yes	No		Yes	No	
☐	☐	Are you having pain or discomfort at this time?	☐	☐	Do you have pain in your jaw?
☐	☐	Do your gums bleed when you brush?	☐	☐	Do you clench or grind?
☐	☐	Do you have history of gum disease?	☐	☐	Do you wear a denture, partial or retainer?
☐	☐	Are you nervous about receiving dental care?	☐	☐	Do you use tobacco products?
☐	☐	Do you have any lumps in or near your mouth?	☐	☐	Do you need to premed for dental treatment?

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient Friend ☐ Another Patient Relative

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ School ☐ Work ☐ Other:_____

Name of person or office referring you to our practice:_____