STIEBEL&BAKER DENTISTRY

PATIENT INFORMATION

PATIENT

Name: _____

Date of Birth: _____ Social Security: _____

Address: _____

Phone: _____ Cell: _____

Place of Business: _____

Business Address: _____

Business Phone: _____

GUARDIAN (IF PATIENT IS A MINOR)

Name: _____

Date of Birth: _____ Social Security: _____

Address: _____

Phone: _____ Cell: _____

Place of Business: _____

Business Address: _____

Business Phone: _____

INSURANCE: ◯ Yes ◯ No IF YES, PLEASE GIVE A COPY OF YOUR CARD TO THE FRONT DESK.

WHO MAY WE THANK FOR YOUR REFERRAL: _____

STIEBEL&BAKER DENTISTRY

DENTAL INFORMATION / HISTORY

1. Have you ever had any serious trouble associated with previous dental treatment? ◯ Yes ◯ No

   If yes, explain: _____

2. Does dental treatment make you nervous? ◯ No ◯ Slightly ◯ Moderately ◯ Extremely

3. Date of last dental visit: _____

4. Have you ever been treated for periodontal disease (gum disease)? ◯ Yes ◯ No

   If yes, explain: _____

5. Do you have or have you ever had any of the following?

MOUTH		TEETH	
YES	NO	YES	NO
◯	◯ Bleeding Gums	◯	◯ Loose Teeth
◯	◯ Unpleasant Taste	◯	◯ Sensitive to Hot
◯	◯ Bad Breath	◯	◯ Sensitive to Cold
◯	◯ Burning Tongue/Lips	◯	◯ Sensitive to Sweets
◯	◯ Frequent Blisters	◯	◯ Sensitive to Biting
◯	◯ Swelling /Lumps in Mouth	◯	◯ Food Impaction
◯	◯ Biting Cheeks/Lips	◯	◯ Clenching/grinding
◯	◯ Clicking/Popping Jaw	◯	◯ Shifting of Teeth
◯	◯ Difficulty Opening or Closing Jaw	◯	◯ Change in Bite

ORAL HYGIENE

1. Do you use the following?

YES	NO	
◯	◯	Electric Toothbrush
◯	◯	Dental Floss
◯	◯	Fluoride Rinse

Other: _____

2. How often do you brush?
   - ◯ Once every few days
   - ◯ Once a day
   - ◯ Twice a day
   - ◯ Three times a day
   - ◯ Four times or more a day

3. Is your brush:
   ◯ Soft ◯ Medium ◯ Hard

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my information, I will inform the dentist at my next appointment.

_____

PRINT NAME

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE