Lake Hills Family Dentistry

PATIENT INFORMATION

Welcome to our office! Please complete both the Registration and Health History forms. The information is important and allows us to provide you with the very best care. As required by law, our office adheres to written policies and procedures to protect the privacy of your information. Your answers are for our records only.

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Your SSN # : _____

Circle Family Status: Married, Single, Child Driver's Lic. # : _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Please check your preferred phone number for appointment confirmation calls.

☐ Cell ( ) _____ ☐ Home ( ) _____ ☐ Work ( ) _____

Spouse or Parent Name and phone: _____

Emergency Name and phone: _____

Whom may we thank for referring you to our office? _____

DENTAL HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Are you apprehensive about dental treatment?	☐	☐	Do you have dry mouth?
☐	☐	Do you gag easily?	☐	☐	Do you smoke or chew tobacco?
☐	☐	Do your gums feel swollen or tender?	☐	☐	Do you have an uncomfortable bite?
☐	☐	Do your gums bleed when you brush or floss?	☐	☐	Do you have face/cheek/joint/temple pain
☐	☐	Does food/floss catch between your teeth?	☐	☐	Does your jaw click, pop or hurt?
☐	☐	Are your teeth sensitve-cold/hot/sweet/pressure?	☐	☐	Do you grind or clench your teeth frequently?
☐	☐	Have you had periodontal (gum) treatment?	☐	☐	Do you wear a night guard?
☐	☐	Do you wear dentures?	☐	☐	Are you satisfied with your smile?
☐	☐	Do you have slow healing sores in or around your mouth?	☐	☐	How often do you brush? _____
			☐	☐	How often do you Floss? _____
☐	☐	Are you experiencing discomfort? If yes, explain: _____			
☐	☐	Have you had problems w/ previous treatment? If yes, explain: _____			

What is your reason for your dental visit today? _____

Pharmacy, location, phone: _____

Medical doctor's name: _____ Phone ( ) _____