BIG COUNTRY FAMILY
Dental

Patient Information Form

Name_____

Age _____ Birthdate _____

SS# _____

Driver's Lic. # _____

Home Address: _____

_____

Home Phone: _____Cell _____Work: _____

❍ Single ❍ Married ❍ Divorced ❍ Widowed

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where and when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/present dentist:_____ Last date visted: _____

Spouse Information

Name:_____

Employer: _____ Work Phone: _____

Birthdate: _____Age: _____ Driver's License # _____

In the event of an emergency, who lives near you that we can contact:

Name: _____ Relationship: _____

Work Phone: _____ Home/Mobile: _____

Dental Insurance

Primary Plan Co. Name: _____ Group or Policy # _____

Insurance Co. Address: _____ Phone # _____

Name of Insured: _____ Relationship: _____

Secondary Plan Co. Name: _____ Group or Policy # _____

Insurance Co. Address: _____ Phone # _____

Name of Insured: _____ Relationship: _____

Dental History

Why have you come to the dentist today?_____

Do you require antibiotics before dental treatment?		❍ Yes	❍ No
Are you currently in pain?		❍ Yes	❍ No
Have you ever had a serious/difficult problem associated with any previous dental work?		❍ Yes	❍ No
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)?		❍ Yes	❍ No
Your current dental health is:	❍ Good	❍ Fair	❍ Poor
Do you like your smile?		❍ Yes	❍ No
Do your gums ever bleed?		❍ Yes	❍ No
Have you ever had periodontal disease?		❍ Yes	❍ No

How many times a week do you floss? _____ times

How many times a day do you brush? _____ times

What type of bristles are on your toothbrush? ❍ Hard ❍ Medium ❍ Soft

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I understand that the information that I have given today is correct to the best of my knowlege. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the above dental information with the patient. Initials _____ Date: _____

Doctor's Comments: _____

Dental History Update

1. Date: _____ Comments: _____ Initial: _____
2. Date: _____ Comments: _____ Initial: _____
3. Date: _____ Comments: _____ Initial: _____