dogwood family dental

DR. KEVIN PATEL | DR. SHEENA PATEL

Patient Name: _____ **SSN**: _____-____-_____

First MI Last

Date of Birth: _____ **Sex**: _____ **Email Address**: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Mailing Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Billing Address (if different): _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Cell Phone**: _____

Employer/Occupation: _____

Primary Dental Insurance Company: _____

Phone: _____ **ID #:** _____

Group #: _____ **Group Plan/Employer:** _____

Subscriber's Name: _____

Date of Birth: _____ **SSN:** _____-___-_____

Emergency Contact & Number: _____

Relationship to Patient: _____

How did you come to choose our office for your dental care? _____

Problems of the jaw:	**Yes**	**No**	**Are your teeth sensitive to...?**	**Yes**	**No**
Clicking of the jaw	☐	☐	Heat	☐	☐
Pain (joints, ears, face)	☐	☐	Cold	☐	☐
Difficulty opening/closing	☐	☐	Sweets	☐	☐
Difficulty chewing	☐	☐	Biting Pressure	☐	☐

General Information:

When was your last dental appointment? _____

Are you dissatisfied with your teeth and their appearance? _____

If yes, what would you change? _____

	Yes	**No**
Have you ever been diagnosed with sleep apnea?	☐	☐

dogwood family dental

DR. KEVIN PATEL | DR. SHEENA PATEL

	Yes	No
Are you currently using any sleep appliance?	☐	☐
Do you sleep well at night?	☐	☐
Do you snore?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around your teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Do you ever avoid any part of your mouth while brushing?	☐	☐
Have you ever had a reaction to local anesthetic?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Are you deeply concerned about finances required to return your teeth to excellent dental health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Have you ever had any teeth removed?	☐	☐

If so, how long have they have been missing? _____

Do you feel you will eventually wear artificial dentures?	☐	☐
Do you smoke?	☐	☐

Do you drink alcohol? _____

If so, drinks per week? _____

To the best of your knowledge, are you or have you ever been afflicted with:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Healing Complications	☐	☐
Diabetes	☐	☐	Allergies to any drugs? _____		
Rheumatic Fever	☐	☐	_____		
Epilepsy	☐	☐	Are you pregnant?	☐	☐
Heart Condition	☐	☐	Are you nursing?	☐	☐
Respiratory Problems	☐	☐	Are you trying to conceive?	☐	☐
Hepatitis	☐	☐	List of Medications: _____		
HIV Positive	☐	☐	_____		
Prolonged Bleeding	☐	☐	_____		

May we use your photos/radiographs for educational or marketing purposes? ☐ ☐

_____ _____

Signature Date