Welcome

We would like to welcome you to our office. In an effort to provide you with the best service possible, we ask that you fill this form out completely. Thank you for your cooperation.

Personal Information

Name: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Telephone: _____(H) _____ (Cell) _____(W)
Employer: _____
DOB: _____ Sex: _____ Marital Status: _____ Referred By: _____

In Case of Emergency

Name: _____ Telephone#: _____

Person Responsible for Account

Name: _____ Relationship: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____(H) _____(Cell) _____(W)

Dental Insurance Information

Primary Insurance Co: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Group#: _____ Subscriber ID:_____
Employee/Subscriber: _____ DOB: _____

Secondary Insurance Co_____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Group#: _____ Subscriber ID:_____
Employee/Subscriber: _____DOB: _____

WYOMING FAMILY DENTISTRY

Patient Dental History

Thank you for selecting our practice. We will strive to provide you with best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us we will be happy to help.

Name_____**Date**_____

Name of Previous Dentist and Location_____
Date of Last Exam_____
How often do you visit the dentist?_____
How often do you brush your teeth?_____
How often do you floss your teeth?_____

Do your gums bleed while flossing?	Yes___	No___
Are you sensitive to hot or cold liquids/foods?	Yes___	No___
Are your teeth sensitive to sweet or sour liquids/foods?	Yes___	No___
Have you ever experienced any of the following problems in your jaw?		
Clicking	Yes___	No___
Pain (joint, ear, side of face)	Yes___	No___
Difficulty in opening or closing	Yes___	No___
Difficulty in Chewing	Yes___	No___
Do you have frequent headaches?	Yes___	No___
Do you clinch or grind your teeth?	Yes___	No___
Have you ever had any orthodontic treatment?	Yes___	No___
Do you wear a denture or partial?	Yes___	No___
If yes, date of placement _____		
Have you ever received oral hygiene instructions		
Regarding the care of your teeth and gums?	Yes___	No___

Do you have any concerns you would like to notify the dentist of in regards to your dental health?

_____
_____
_____

If you could change anything about your smile, what would you change?

_____
_____
_____

Appointment Time Preference ____AM ____PM

Preferred Pharmacy_____

WYOMING FAMILY DENTISTRY