MARTIN DENTAL CARE
• TRUSTED & COMFORTABLE •

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. This information is vital to allow us to provide appropriate care.

PATIENT NAME Last _____ First _____ MI _____ SEX: M F

PATIENT INFORMATION AND HEALTH HISTORY

NAME YOU PREFER TO BE CALLED _____ DOB _____ AGE _____ S.S.# (Required) _____

HOME PHONE _____ CELL _____ E-Mail Address (Optional) _____

PATIENT'S HOME ADDRESS Street _____ City _____ State _____ Zip _____

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

IF MARRIED, SPOUSE'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUSINESS PHONE _____

EMERGENCY CONTACT PERSON _____ RELATIONSHIP _____ PHONE _____

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT THAN ABOVE) _____ S.S.# (Required) _____

ADDRESS Street _____ City _____ State _____ Zip _____ PHONE _____

EMPLOYED BY _____ BUSINESS PHONE _____

WHOM MAY WE THANK FOR REFERING YOU TO THIS OFFICE? _____

DENTAL INSURANCE COVERAGE (IF ANY) SUBSCRIBER NAME _____ PHONE _____

RELATION TO PATIENT _____ DOB _____ S.S. # OR I.D. # OF SUBSCRIBER (Required) _____

SUBSCRIBER'S ADDRESS Street _____ City _____ State _____ Zip _____

EMPLOYER _____ PHONE _____

PLAN NAME _____ GROUP NO _____

INSURANCE CO _____ YEARLY MAX ALLOWANCE $ _____

CLAIMS ADDRESS Street _____ City _____ State _____ Zip _____

INSURANCE: To avoid any misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain and maximize your insurance benefits. We do not render our services on the basis that insurance companies will pay all our fees.

INDICATE ☑ YES OR ☑ NO IF YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

YES	NO		YES	NO	
☐	☐	Active Tuberculosis	☐	☐	Persistant cough greater than a three week duration
☐	☐	Cough that produces blood	☐	☐	Been exposed to anyone with Tuberculosis

IF YOU ANSWER YES TO ANY OF THE 4 ITEMS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

DENTAL HISTORY

DATE OF LAST DENTAL EXAM _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?(Chief Dental Complaint) _____

INDICATE ☑ YES OR ☑ NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING.

YES	NO		YES	NO	
☐	☐	Injury to your face or jaws	☐	☐	Complications from extractions
☐	☐	Recent pain or tenderness in or about the mouth	☐	☐	Previous periodontal (gum) treatment
☐	☐	Canker or cold sores	☐	☐	Previous orthodontic treatment
☐	☐	Teeth sensitive to cold, hot, sweets, or pressure	☐	☐	Previous treatment for a temporomandibular disorder (TMJ)
☐	☐	Swellings or lumps in the mouth or neck	☐	☐	Do you wear dentures or partials?
☐	☐	Swollen or bleeding gums when brushing or flossing	☐	☐	Do you like the appearance of your teeth and your smile?
☐	☐	Bad breath or unpleasant taste	☐	☐	Do you have spaces that you don't like?
☐	☐	Loose teeth	☐	☐	Do you like the color of your teeth?
☐	☐	Clench or grind your teeth	☐	☐	Do you like the shape and alignment of your teeth?
☐	☐	Smoke cigarettes, pipe, cigar, or chew tobacco	☐	☐	Are there old fillings or dental work that you don't like looking at?
☐	☐	Dry mouth	☐	☐	Is your home water supply fluoridated?
☐	☐	Food or floss catching between teeth	☐	☐	Do you participate in active recreational activities?

How often do you brush? _____ Do you use dental floss? _____ How often? _____

Do you use other home dental care products or techniques? _____

COMMENTS _____