ALLEN & NEUMANN
FAMILY DENTISTRY

Patient Information

Patient Name ____________________ Date of Birth ____________________
Social Security # ____________________ Marital Status ____________________
Patient Address ____________________ City, State, Zip ____________________
Home Phone ____________________ Work Phone ____________________
Email address ____________________ Cell Phone ____________________
Emergency Contact Name and Number____________________
What is the best way to confirm your dental appointments? ____________________
Patient's employer ____________________ Present position: ____________________
Spouse's employer ____________________ Present position: ____________________
Will the fees for our services be offset by dental insurance? Yes / No
Subscriber Name____________________ Relationship to patient____________________
Subscriber DOB: ____________________Name of Dental Ins. ____________________
Identification Number ____________________Group Number ____________________
Who may we thank for referring you to our office? ____________________

Dental History

Are you aware of any dental problems at this time? ____________________
How long has it been since you have been to a dentist? ____________________
What was done then? ____________________
Previous Dentist's name ____________________ Address ____________________
Have you had any problems or complications with previous dental treatment? Yes/No ____________________
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Have you ever had any of the following dental procedures done? If so, please explain.
Periodontal Surgery or Scaling and Root Planing? Yes/No ____________________
Orthodontic Treatment Yes/No ____________________
Oral Surgery Yes/No ____________________
Endodontic Treatment Yes/No ____________________
Have you ever whitened your teeth? Yes/No Are you interested in whitening? ____________________
Have you lost any teeth or have any teeth been removed? Yes/No Why? ____________________

Do you experience any of the following:

❑Yes ❑No Hot/Cold Sensitivity
❑Yes ❑No Unpleasant Breath
❑Yes ❑No Bleeding or Tender Gums
❑Yes ❑No Food gets caught easily
❑Yes ❑No Frequently get cavities
❑Yes ❑No Clench or grind your teeth
❑Yes ❑No Difficulty opening or closing
❑Yes ❑No Jaw clicks, pops, or locks
❑Yes ❑No Pain or soreness in your face or by your ear
❑Yes ❑No Build up a lot of plaque/calculus
❑Yes ❑No Eat or drink frequently between meals

How often do you brush? ____________________ How often do you floss? ____________________
What other products/rinses do you use? ____________________
Do you usually have teeth numbed for dental work? Yes/No
If you could change anything about your teeth or smile what would that be? ____________________
Are you planning to keep your remaining teeth your whole lifetime? Yes/No ____________________
Is there anything we can do to make your dental appointment more comfortable?____________________

I certify that the above information is complete and accurate.

Patient/Guardian Signature____________________ Date:____________________
Dentist's Initials ____________________ Date:____________________

Complete Reverse Side