WEST MALL
DENTAL GROUP
FAMILY DENTISTRY

NEW PATIENT FORM

INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING):

SUBSCRIBER:	RELATION:	INSURANCE CO:
POLICY PLAN #:	DIVISION/SECT.#:	SUBSCRIBER ID:
SUBSCRIBER (SECONDARY)	RELATION:	INSURANCE CO:
POLICY PLAN #:	DIVISION/SECT.#	SUBSCRIBER ID:

PATIENT DENTAL HISTORY

1. Reason for today's visit: ____________________
2. Does the patient have a dental problem that needs to be addressed as soon as possible? .... Y ☐ N ☐ O ☐
3. Has the patient been visiting the dentist regularly? .... Y ☐ N ☐ O ☐
4. Last dental visit: __________ Cleaning: __________ Full mouth x-rays: __________
5. How often does the patient brush his/her teeth? __________ Floss his/her teeth? __________
6. Do the patient's gums bleed regularly? .... Y ☐ N ☐ O ☐
7. Are the patient's teeth sensitive to: .... Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Sour ☐ N/A ☐
8. Does the patient feel any pain in his/her teeth? .... Y ☐ N ☐ O ☐
9. Has the patient ever had any head, neck or jaw injuries? .... Y ☐ N ☐ O ☐
10. Has the patient ever had jaw joint surgery? .... Y ☐ N ☐ O ☐
11. Does the patient have difficulty swallowing? .... Y ☐ N ☐ O ☐
12. Does any part of the patient's mouth hurt when clenched? .... Y ☐ N ☐ O ☐
13. Does the patient's jaw crack, click or pop when opened widely? .... Y ☐ N ☐ O ☐
14. Does the patient grind or clench his/her teeth during the day or night? .... Y ☐ N ☐ O ☐
15. Does the patient bite his/her lips/cheeks frequently? .... Y ☐ N ☐ O ☐
16. Has the patient ever experienced any growths, lumps or sore spots in his/her mouth? .... Y ☐ N ☐ O ☐
17. Has the patient noticed any loosening/movement of his/her teeth? .... Y ☐ N ☐ O ☐
18. Has the patient had periodontal (gum) treatment? .... Y ☐ N ☐ O ☐ If yes, date completed: __________
19. Has the patient had orthodontic treatment? .... Y ☐ N ☐ O ☐ If yes, date completed: __________
20. Has the patient ever had treatment by a dental specialist? Y ☐ N ☐ O ☐ If yes, please specify: __________
21. Has the patient had previous problems with dental treatment? .... Y ☐ N ☐ O ☐
22. Is the patient satisfied with the appearance of his/her teeth? .... Y ☐ N ☐ O ☐
23. Is the patient nervous during dental treatment? .... Y ☐ N ☐ O ☐
24. Please list any other information that you feel we should have to provide the patient with the best possible dental care:

____

(Signature) PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ DATE

(Reviewed By Dentist): DATE