



Patient information

Last Name First Age Birth date M F SSN (for accounting purposes only)

Address Home Phone Alternate Phone email

City State Zip Emergency contact name and phone

Employer name Employer address City State Zip

Are you covered by dental insurance? Yes No (if yes, please complete this section and present your insurance card)

_____ Primary Insurance Company Name	_____ Policy Holder's Name and DOB	_____ Policy Holder's Insurance ID / SSN
_____ Primary Insurance Company Address	_____ Policy Holder's Employer	_____ Group ID #
_____ Secondary Insurance Company Name (if any)	_____ Policy Holder's Name and DOB	_____ Policy Holder's Insurance ID / SSN
_____ Secondary Insurance Company Address	_____ Policy Holder's Employer	_____ Group ID #

Please tell us how we can be of service

1. Are you feeling any pain today? Yes No
2. If yes, where is the pain located? _____ Is there any swelling associated with the tooth? Yes No
3. When did you first notice symptoms? _____ Did symptoms occur suddenly or gradually? _____
4. Please indicate the intensity, frequency, and quality of your discomfort or pain:
Intensity: On a scale of 1 to 10 (1=mild, 10=severe) _____
Frequency: Constant Intermittent Momentary Occasional
Quality: Sharp Dull Throbbing
5. Is there anything you can do to relieve the pain? Yes No If yes, what? _____
6. Is there anything that provokes pain or that you do to cause the pain to increase? If yes, what? _____
7. When eating or drinking, is your tooth sensitive to: Sweets Heat Cold
8. Does your tooth hurt when you bite down or chew? Yes No
9. Does it hurt if you press the gum tissue around this tooth? Yes No
10. Does a change in posture (lying down or bending over) cause your tooth to hurt? Yes No
11. Do you grind or clench your teeth? Yes No If yes, do you wear a splint or night guard? Yes No
12. Has a restoration (filling or crown) been placed on this tooth recently? Yes No
13. Prior to this appointment, has root canal therapy been started on this tooth? Yes No
14. Have you had any recent or past trauma or injury to this tooth? Yes No
15. Please tell us what you need to feel well cared for:

With my signature I certify that I have read and understood the informed consent and financial policies (attached), agree to abide by them, and will pay today with one of the following: check cash credit card. With my signature, I also certify that I have had the opportunity to review the office's Notice of Privacy Practices (HIPAA form).

Signature (patient / guardian): _____ Date: _____