REIDER FAMILY DENTISTRY

Patient Information

Please fill in the following information on both sides. Thank you.

Today's Date: _____

Patient's last name: _____ First: _____ Middle: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other DOB: _____

Street Address: _____ SSN: _____

City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____

Employer: _____ Work phone #: _____

Email: _____ Preferred method of contact: (Please check one only) ☐ Home ☐ Cell ☐ Work ☐ Email

Spouse's Name: _____ Spouse phone #: _____

Whom may we thank for referring you to our office? _____

Other family members seen in our office: _____

Dental Insurance Information

Please give your insurance card to the receptionist

Subscriber's name: _____ Subscriber's SSN: _____

Subscriber's DOB: _____ Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Subscriber's Address: (if different from above) _____

Subscriber's Employer: _____ Subscriber's ID #: (If different from SSN) _____

Dental Ins. Company: _____ Group Number: _____

In Case of Emergency

Name of local relative or friend (not living at the same address): _____

Relationship to patient: _____ Phone #: _____

The above information is true to the best of my knowledge. I authorize my dental insurance benefits be paid directly to the dental practice. I understand that I am financially responsible for any balance. I also authorize Reider Family Dentistry or my dental insurance company to release any information required to process my claims.

Patient Signature *Date*

Please continue on the back…

REIDER FAMILY DENTISTRY

Dental History

It is **important** that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the medical and dental questions and discuss them with you. Information you give us is *confidential* and will not be released to anyone without your permission.

Please check **Yes** or **No** to the following dental history questions:

Have you experienced any growth or sore spots in or around your mouth?	☐ Yes	☐ No
Is any part of your mouth sore to pressure or irritants?	☐ Yes	☐ No
Do your gums bleed?	☐ Yes	☐ No
Has your mouth seemed unusually dry recently?	☐ Yes	☐ No
Do you chew on only one side of your mouth?	☐ Yes	☐ No
Do you habitually clench your teeth anytime?	☐ Yes	☐ No
Do you ever experience jaw clicking, popping, or discomfort?	☐ Yes	☐ No
Any prolonged bleeding after extractions?	☐ Yes	☐ No
Have you had injury or trauma to the face or jaw?	☐ Yes	☐ No
Have you had reactions or allergic symptoms to dental anesthetic?	☐ Yes	☐ No
Have you had complications following any dental visit?	☐ Yes	☐ No
Do you have frequent headaches, earaches, or neck pain?	☐ Yes	☐ No
Have you ever had instruction on the correct method of brushing your teeth?	☐ Yes	☐ No
Do you have *removeable* dentures or partial dentures?	☐ Yes	☐ No
Do you wish to hear about whitening options?	☐ Yes	☐ No
Are you unhappy about the appearance of your teeth or smile?	☐ Yes	☐ No
Check any of the following treatments that you have had in the past.	☐ Yes	☐ No

☐ Braces ☐ Wisdom Tooth Extraction ☐ Root Canal ☐ Gum Surgery

When were your last dental x-rays taken? _____

Where? _____

Is there any treatment that you are seeking now, or would like information about? ☐ Yes ☐ No

If yes, please explain: _____

Please check the number below to honestly rate your dental anxiety level as this will help us better serve your needs. (1 = *Comfortable; 10 = Fearful)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

_____ _____

Patient Signature *Dentist's Signature*