



ALLEN FAMILY DENTISTRY

JEFFREY F. ALLEN, D.D.S.

Patient Information

Patient Name _____ Date of Birth _____
 Social Security # _____ Marital Status _____
 Patient Address _____ City, State, Zip _____
 Home Phone _____ Work Phone _____
 Email address _____ Cell Phone _____
 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 _____
 Name of Dental Insurance Company _____
 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 ever been told to take antibiotics prior to your dental appointment? Yes/No _____
 Have you had any problems or complications with previous dental treatment? Yes/No _____

Have you ever had any of the following dental procedures done? If so, please explain.

Gum Treatments or Periodontal Surgery? 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 or have you ever experienced any of the following:

_____ Hot/Cold Sensitivity	_____ Clench or grind your teeth
_____ Unpleasant Breath	_____ Difficulty opening or closing
_____ Bleeding Gums	_____ Jaw clicks, pops, or locks
_____ Tender Gums	_____ Frequently get cavities
_____ Food gets caught	_____ Build up a lot of plaque/calculus
_____ Pain or soreness in your face or by your ear	

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