MARK C. FRILL DDS

At Val Verde Dental

Office Use Only:
Insurance:
Yes___
No___
Verified:_____

How did you hear about us?_____

Patient Information

Last Name:_____First Name:_____Middle Initial:_____

Address:_____City:_____ST:___Zip:_____

Home Phone:_____Work Phone:_____Mobile Phone:_____

Email Address:_____What is the best way to contact you?_____

Sex: M_F__ Marital Status:_____Birth Date:_____Social Security #:_____

Emergency Contact Name:_____Emergency Contact Number:_____

Medical Doctor:_____Doctor's Phone #:_____

Responsible Party (if different from above)

Last Name:_____First Name:_____Middle Initial:_____

Address:_____City:_____ST:___Zip:_____

SS#:_____ Birth Date:_____

Home Phone:_____Work Phone:_____Mobile Phone:_____

Primary Insurance Information

Company Name:_____Policy Number:_____

Name of Insured:_____Relationship to Insured:_____

Street Address:_____City:_____ST:___Zip:_____

Phone:_____Social Security #:_____Date of Birth:_____

Employer Name:_____Medicaid ID (if applicable):_____

If Student, Name of School:_____City:_____Full/Part time:_____

Dental History Questionnaire

Patient's Name:_____Date:_____

Date of last dental visit_____Last dental cleaning_____

Dates of last dental x-rays_____How often do you have a dental examination?_____

How often do you brush your teeth?_____How often do you floss?_____

Do you use any dental aids? (Sonicare, Braun, toothpick, etc.)_____

Do you have active dental problems now? ____Yes No____

If yes, please describe the problem_____

Do you have trouble with bad breath?_____ Do you have any loose teeth?_____

If you could change one thing about your teeth or smile, what would it be?_____

_____

Have you ever had orthodontics?_____Were you pleased with the result?_____

Would you like to learn more about what orthodontic options are available?_____

Have you ever whitened your teeth?_____Were you pleased with the result?_____

Would you like to learn more about whitening options?_____

Do you have any silver fillings that you would like replaced with tooth colored restorations?_____

Do you have any other questions or concerns you would like us to address?_____

_____

Have you ever had:

Oral surgery or teeth removed	___ Yes No ___
Periodontal treatment	___ Yes No ___
Endodontic treatment	___ Yes No ___
Broken jaw	___ Yes No ___
Missing back teeth	___ Yes No ___
A bite splint or mouth guard	___ Yes No ___

Are any of your teeth sensitive to:

___ Hot or cold ___ Sweets ___Biting or chewing