Office Use Only:
Insurance:
Yes____
No_____
Verified:_______

At Portal Ridge Dental

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:___________________________________ 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