WELCOME

Thank you for selecting our office to provide your dental care. We strive to provide the finest dental care possible for you and your family. If you ever have any questions or concerns, please do not hesitate to call the office. You are also encouraged to call Dr. Nestlerode any time on his cell phone (available on the office recording), if you have a question or a dental emergency.

PATIENT INFORMATION

Date_____
SS/HIC/Patient ID #_____
Patient Name_____
Address_____ Zip_____
City_____
State_____
Email_____
Sex ☐ M ☐ F Age_____ Birthdate _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____years

Occupation_____
Patient Employer/School_____
Employer / School Address_____
_____
Employer/ School phone (____)_____
_____
Spouse's Name_____
Birthdate _____ SS#_____
Spouse's Employer_____
Whom may we thank for referring you?_____

DENTAL INSURANCE

Subscriber's Name_____
Relationship to Patient_____
Birthdate_____ SS#_____
Insurance Co._____
Group#_____Phone (____)_____

Is patient covered by secondary insurance? ☐ Yes ☐ No
Subscrber's Name_____
Relationship to Patient_____
Birthdate _____ SS#_____
Insurance Co. _____
Group #_____ Phoenix (___)_____

PHONE NUMBERS

Home (____)_____Work (_____)_____Ext. _____ Cell Phone(____)_____
Spouse's Work (_____) _____ Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
Name _____ Relationship _____
Home Phone (_____) _____ Work (_____) _____ Ext. _____ Cell Phone (_____) _____

Dental History

Please check ( ) "Yes" or "No" to indicate if you have had any of the following

Reason for today's visit _____
_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

How often do you floss?_____

How often do you brush?_____

Do you wear contact lenses? ☐ Yes ☐ No

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on onside of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No
			Do you require antibiotics before dental treatment	☐ Yes	☐ No

-OVER-