Patient Information

Date Called ____________________ Appointment Date ____________________

Name	Home Phone	
Address	Other Phone	
	E-mail	
Insurance Information:	Employer	
	DOB	SS#

New Patient

Pre-Medication ☐ Yes ☐ No (If yes) Any Allergies to Medications ______________________________		
FMX - PAN ☐ Yes ☐ No	FMX Requested (Date)	FMX Received (Date)
Previous Dentist: Name_________________________ Telephone _____________________________		
Other comments:		
Who may I thank for referring you to our practice?		

Emergency Patient

New Patient ☐ **Patient of Record** ☐
Reason? ☐ Toothache ☐ Broken Tooth ☐ Facial Pain ☐ Other
How long has the tooth been hurting?__________ Does it keep you awake at night?__________ What have you been taking for the discomfort?_______________
Location? ☐ Upper Right ☐ Lower Right ☐ Upper Left ☐ Lower Left
Is the tooth sensitive to? ☐ Hot ☐ Cold ☐ Pressure
Swelling? ☐ Yes ☐ No
Symptoms? ☐ Constant ☐ Intermittent ☐ Sharp pain ☐ Dull pain ☐ Throbbing Pain
Comments:
Who may I thank for referring you to our practice?