Lynchburg Dental Center

Welcome to our office! We appreciate the trust you have placed in us and we will make every effort to make your visit to our office pleasant.

PATIENT INFORMATION, HEALTH HISTORY & OFFICE POLICY *(Please Print)*

Patient Last Name: ______________________ First: ______________________ MI: __________

Preferred Name: ______________________ Date Of Birth: ______________ Sex: M ☐ F ☐

Home Address: ______________________ City/State: ______________________ Zip: __________

Home Phone: ______________________ Cell Phone: ______________________ E-mail: ______________________

Marital Status: Married ☐ Single ☐ Other ☐ Spouse Full Name: ______________________

SS#__________________ __ Driver's License #____________________Referred By:______________________

Person Responsible For Account: ________________Phone (if different) _________ Physician Name: ______________________

Work Phone: ______________________ (Ext: _______) Employer/Occupation: ______________________

Primary Dental Insurance: ______________________ Employer: ______________________

Subscriber's Full Name: ______________________ SS#: ______________________ Date of Birth: __________

Secondary Dental Insurance: ______________________ Employer: ______________________

Subscriber's Full Name: ______________________ SS#: ______________________ Date of Birth: __________

DENTAL HEALTH HISTORY

If any of the following apply to the dental patient being seen, please indicate by placing a √ in the box.

☐ Complications From Extractions ☐ Unpleasant Taste ☐ Periodontal Treatment ☐ Bleeding Gums

☐ Swelling or Lumps in Mouth ☐Clenching or Grinding ☐ Frequent Blisters on Mouth ☐ Bad Breath

☐ Oral Habits (Nail Biting, Cheek Biting, *Etc.*) ☐ Allergy or Sensitivity to Metals ☐ Pain Around the Ear

☐ Sensitivity to cold, heat, sweets, or pressure ☐ Allergy or Sensitivity to Latex ☐ Headaches

☐ Popping, Cracking or Locking of Jaw Joints ☐ Pain Upon Opening/Closing ☐ Muscle Spasm Upon Opening/Closing

1. What is the reason for your visit? ____
2. Do you require PRE-MEDICATION? ____
3. Date of Last Dental Exam: _______/_______/________ Date of Last Dental X-rays: _______/_______/________
4. How often do you brush your teeth? _____ ☐ Daily ☐ Weekly ☐ Monthly Floss? ___ ☐ Daily ☐ Weekly ☐ Monthly
5. What type of toothbrush bristle are you currently using? ☐ Ultra Soft ☐ Soft ☐ Medium ☐ Hard
6. Do you use? ☐ Electric Toothbrush ☐Water Jet Device
7. How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)
8. If you could make any changes to your smile, what would they be? ______________________________

CONTINUED ON BACK

- Our office is dedicated to providing optimal care for every patient and working with you to achieve that goal.
- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

______________________________ ______________________________
Patient Signature Date

____
Staff/Date

Student Information

Name of School or University: ______________________________

City and State: ______________________________

Status: ______________________________ **Full-time or Part-time**

WELCOME!