We would like to get to know you better! Walton Blvd. Dental

Roberts & Criswell, DDS, PA · Sarah Beers, DDS · Eric Mathis, DDS · Kendall Roberts, DDS

PERSONAL INFORMATION Date _____

First name _____ Middle Initial _____ Last name _____

◯ Male ◯ Female

Patient's SS # _____-_____-_____ DL# _____ DOB _____/_____/_____

Street address _____

City/state/zip _____

E-mail address _____

Home phone _____ Work phone _____ Cell phone _____

If child: Parent's name _____ Middle Initial _____ Last name _____

DOB _____/_____/_____ SS # _____-_____-_____

Street Address: _____

City/state/zip _____

Employer _____ Phone _____ Occupation _____

Spouse's name _____ SS # _____-____-_____ DOB _____/_____/_____

Employer _____ Phone _____ Occupation _____

Emergency contact _____ Relationship _____ Phone _____

How were you referred to our office?

◯ Friend/family: name _____ ◯ Radio ◯ Television ◯ Phonebook ◯ Website/internet

◯ Insurance provider list Social media: ◯ Facebook ◯ Twitter ◯ other _____

FOR INSURANCE PURPOSES

Insurance company _____ Subscriber name_____

SS#/id# _____ DOB _____/_____/_____ Group # _____

Are you covered by another plan? _____ Insurance company _____

Subscriber name_____ _____ SS#/id# _____

DOB _____/_____/_____ Group # _____

Are your teeth sensitive to:	YES	NO
Hot?	◯	◯
Cold?	◯	◯
Sweets?	◯	◯
Biting pressure?	◯	◯
Does food catch btwn your teeth?	◯	◯
Do your gums bleed when brushing?	◯	◯
Have you noticed any gum swelling around any teeth?	◯	◯
Do you have an unpleasant taste or odor in your mouth?	◯	◯
Problems of the jaw:		
Clicking of the jaw	◯	◯
Pain (joints/eat/side of face)	◯	◯
Difficulty opening or closing	◯	◯
Difficulty chewing	◯	◯
Do you ever avoid any part of the mouth while brushing?	◯	◯
Have you had a reaction to local anesthetic?	◯	◯
Are you dissatisfied with your teeth & their appearance?	◯	◯
Are you deeply concerned about the finances required to return your mouth to excellent health?	◯	◯
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	◯	◯
Do you smoke?	◯	◯
Have you ever had any teeth removed?	◯	◯

How long have these teeth been missing? _____

Do you feel you will eventually wear artificial dentures?	◯	◯
Do you have fears?	◯	◯

When was your dental appointment? _____

	YES	NO
Do you have any general health problems?	◯	◯

If so, please specify _____

_____

_____

Have you had surgery?	◯	◯

If so, please specify _____

_____

_____

Are you currently under a physician's care?	◯	◯

Reason _____

_____

_____

Do you take any medications?	◯	◯

Please list _____

_____

_____

To the best of your knowledge, are you or have you ever been afflicted with:

Heart ailment	◯	◯
Diabetes	◯	◯
Rheumatic fever	◯	◯
Epilepsy	◯	◯
High blood pressure	◯	◯
Respiratory disease	◯	◯
Hepatitis	◯	◯
HIV positive	◯	◯
Prolonged bleeding	◯	◯
Healing complications	◯	◯
Allergy to any drugs	◯	◯

If yes, please specify _____

_____

_____

Allergic to latex?	◯	◯
Are you pregnant?	◯	◯

If yes, month _____

What is your present dental problem? _____

_____

_____

_____

_____

_____

_____

_____

SIGNATURE _____