

Val Verde Dental LLC

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Office Use Only:

Insurance:

Yes ___

No ___

Verified: _____

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: _____ Medicaid ID (if applicable): _____

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? _____

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

Cosmetic Analysis

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? _____