BEBAR FAMILY DENTAL

ALL INFORMATION IS CONFIDENTIAL

We would like to thank you for allowing us to serve You. Remember! We are only a phone call away.

(PLEASE PRINT)

Mr. ☐ Mrs. ☐ Ms. ☐

SINGLE ☐ MARRIED ☐
SEPARATED ☐ DIVORCED ☐

Patients Last Name | First | MI | SS# | Birth Date

Home Address | City | State | Zip Code | Home Phone & Cell

Person to contact in case of emergency | Phone#

Who will pay for this account? *(If different from patient)* | Birth Date | SS# | Drivers License#

Responsible Party Employed By | City | State | Zip Code | Business Phone# | How Long Held

Dental Insurance Co. | Address | City | State | Zip Code | Phone#

Spouse Name | First | MI | Birth Date | SS# | Drivers License#

Spouse Employed By | City | State | Zip Code | Business Phone#

Spouse Dental Insurance Co. | Address | City | State | Zip Code | Phone#

If Patient is a Child (Mothers Name) | SS# | Drivers License# | Birth Date

Fathers Name | SS# | Drivers License# | Birth Date

WHOM MAY WE THANK FOR REFERRING YOU?

YOUR DENTAL HISTORY

How long has it been since you have been to a dentist? ______________________

What was done at the time? ______________________

____

	YES	NO
Are you having discomfort now?	☐	☐
Are your teeth sensitive?	☐	☐
To what? ______________		
Have you lost any teeth?	☐	☐
Have you had a lot of dental problems?	☐	☐
Are you afraid of dentistry?	☐	☐
Have you had any bad dental experiences?	☐	☐
Do your gums bleed?	☐	☐
Do your teeth feel slightly loose?	☐	☐
Do you have bad breath at times?	☐	☐
Does food pack anywhere?	☐	☐
Orthodontic appliances worn now or ever been ______________	☐	☐
Do you have trouble chewing on either side?	☐	☐

	YES	NO
Do you have any popping or crunching sounds in your ears?	☐	☐
Are either of your jaws tender at times?	☐	☐
Do you grind or clinch your teeth while sleeping or during the day?	☐	☐
Do you have facial pain?	☐	☐
When? ______________		
Do you have headaches?	☐	☐
Do you have neckaches?	☐	☐
Do you have backaches?	☐	☐
Do you like the way your teeth look?	☐	☐
Do you floss your teeth?	☐	☐
Do you want to avoid dentures?	☐	☐
Every thing has a cause. Would you be willing to learn how to remove whatever caused your problems?	☐	☐

IF PATIENT IS A CHILD

	YES	NO
Child's attitude to dentistry______________		
Is fluoride taken in any form?	☐	☐
Does you child brush teeth daily?	☐	☐
Do you assist child with tooth brushing?	☐	☐

OVER . . .