Bolton
Family Dental Centre

PATIENT INFORMATION

❑Mr. ❑ Ms. ❑ Mrs. ❑ Dr.

Name: ____

Address: ____

City/Postal Code: __________________________________

E-mail Address: ____________________________________

Phone: __________________ Cell: ______________________

Birth Date: ____/____/____ (Month Day Year) Age: ____ ❑ Male ❑ Female

In Case of Emergency Please Contact: ______________________

Phone: ________________________

PERSON RESPONSIBLE FOR ACCOUNT

❑ Self ❑ Spouse ❑ Parent ❑ Guardian ❑ Other

Name: ____

Address: ____

Phone: __________________Cell: ________________________

Birth Date: ____/____/____ (Month Day Year) Age: ____ ❑ Male ❑ Female

Employer ____

Work Phone: _______________________ EXT: _____________

Occupation: ____

REFERRAL

Who can we thank for your referral? ______________________

Can we friend you on facebook? ❑ Yes ❑ No

If yes what is your facebook Name? ___________________

INSURANCE INFORMATION

Primary Insurance – Name of insured:________________________

Insurance company: _____________________________________

Policy#____________ Cert#______________ Div# ________

Relation: ❑ Self ❑ Spouse ❑ Other Birth Date:____/____/____ (Month Day Year)

Secondary Insurance – Name of insured:______________________

Insurance company: _____________________________________

Policy#______________ Cert#____________ Div# ___________

Relation: ❑ Self ❑ Spouse ❑ Other Birth Date: ____/____/____ (Month Day Year)

DENTAL HISTORY

Previous Dentist: __________________ Phone: ______________

Last Dental X-Rays: __________________

Last Cleaning: _______________________

Any previous problems with dental treatment?:_________________
____

Are you satisfied with the appearance of your teeth?
Y❑ N❑ Explain: _______________________

PAST HISTORY

- Y❑ N❑ Gum Surgery?
- Y❑ N❑ Orthodontics (Braces)
- Y❑ N❑ Endodontics (Root Canal)
- Y❑ N❑ Oral Surgery
  - ❑ Wisdom teeth removal
  - ❑ Dental Implants
  - ❑ Crowns
  - ❑ Bridges
  - ❑ Dentures

PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:

TEETH

- ❑ Broken/Chipped/Cracked
- ❑ Missing Tooth or Teeth
- ❑ Decay
- ❑ Loose Teeth
- ❑ Mouth Breathing
- ❑ Difficulty Chewing
- ❑ Food Trap Areas
- ❑ Grinding or Clenching
- ❑ Oral Habits: ___________
- ❑ Mouth Sores
- ❑ Sensitive to Hot/Cold
- ❑ Sensitive to Sweets
- ❑ Tooth Pain
- ❑ Sinus Problems
- ❑ Burning Tongue/Lips/ Dry Mouth
- ❑ Gum Surgery
- ❑ Shifting teeth

GUMS

- ❑ Bleeding/Sore Gums
- ❑ Bad Breath
- ❑ Sore or Sensitive
- ❑ Swelling or Lumps

Jaw/Facial Pain Problems

- ❑ Facial Pain
- ❑ Frequent Headaches
- ❑ Jaw Clicks
- ❑ Pain in Cheeks or Temples
- ❑ Difficulty Opening

OTHER CONCERNS OR REASONS FOR VISIT?:

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OVER→