



325 University Ave.
Syracuse, NY 13210
(315) 476-3552

Please complete all sheets and return to the front desk. Thank you.

PATIENT INFORMATION		
NAME: LAST	FIRST:	MIDDLE:
ADDRESS:		
CITY:	STATE:	ZIP:
BIRTHDATE: ___/___/___	AGE: SS#: ___-___-___	MARITAL STATUS:
S/M/D/W		
EMPLOYER:	OCCUPATION:	
PHONE: HOME # ()	WORK # ()	CELL # ()
PERSON RESPONSIBLE FOR BILL (IF DIFFERENT FROM ABOVE INFORMATION)		
NAME: LAST	FIRST:	MIDDLE:
ADDRESS:		
CITY:	STATE:	ZIP:
BIRTHDATE: ___/___/___	AGE: SS#: ___-___-___	MARITAL STATUS:
S/M/D/W		
EMPLOYER:	OCCUPATION:	
PHONE: HOME # ()	WORK # ()	CELL # ()
PRIMARY DENTAL INSURANCE		
INSURED FULL NAME:	BIRTHDATE: / /	
RELATIONSHIP TO PATIENT:	SS#: - -	
EMPLOYERS NAME:	EMPLOYERS PHONE: () -	
EMPLOYERS ADDRESS:		
CITY:	STATE:	ZIP:
INSURANCE CO. NAME:	GROUP #:	PLAN #:
INSURANCE CO. ADDRESS:	INS. CO. PHONE:	
CITY:	STATE:	ZIP:
SECONDARY DENTAL INSURANCE		
INSURED FULL NAME:	BIRTHDATE: / /	
RELATIONSHIP TO PATIENT:	SS#: - -	
EMPLOYERS NAME:	EMPLOYERS PHONE: () -	
EMPLOYERS ADDRESS:		
CITY:	STATE:	ZIP:
INSURANCE CO. NAME:	GROUP #:	PLAN #:
INSURANCE CO. ADDRESS:	INS. CO. PHONE:	
CITY:	STATE:	ZIP:

GETTING TO KNOW YOU

1. WHOM MAY WE THANK FOR REFERRING YOU?

2. WHEN WAS YOUR LAST DENTAL VISIT

DATE OF LAST FULL SET OF X-RAYS: / /

3. WHO WAS YOUR PREVIOUS DENTIST?

PHONE #: () -

4. WHAT ARE YOUR PRIMARY DENTAL CONCERNS?

5. DO YOU HAVE ANY DISCOMFORT WHEN YOU CHEW OR BITE? YES NO

WHERE OR WHEN:

6. DO YOU HAVE ANY TEETH THAT ARE SENSITIVE TO HOT, COLD, SWEETS? YES NO

EXPLAIN:

7. ARE YOU HAVING ANY OTHER PROBLEMS? YES NO EXPLAIN:

8. HOW OFTEN DO YOU HAVE YOUR TEETH EXAMINED AND CLEANED?

9. HAVE YOU HAD MUCH DENTAL TREATMENT IN THE PAST? YES NO EXPLAIN:

10. DO YOU HAVE CONCERNS ABOUT THE DENTAL CARE YOU HAVE HAD IN THE PAST: YES NO

EXPLAIN:

11. ARE YOU MISSING ANY TEETH? YES NO

IF YES, DO YOU REGRET LOOSING THEM? YES NO

12. HAVE YOU EVER WORN BRACES? YES NO IF YES, WHEN? FOR HOW LONG?

13. DOES YOUR BITE FEEL COMFORTABLE? YES NO

CAN YOU CHEW AS WELL AS YOU WOULD LIKE TO? YES NO

14. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR SMILE/TEETH? YES NO

IF NO, WHAT IS IT THAT YOU WOULD LIKE TO CHANGE?

15. WHAT IS YOUR DAILY ORAL HYGIENE ROUTINE?

DO YOUR GUMS BLEED WHEN YOU BRUSH? YES NO

16. HOW OFTEN DO YOU SUFFER FROM BAD BREATH?

RARELY OCCASIONALLY OFTEN

17. DO YOU USE GUM, BREATH MINTS OR COUGH DROPS?

RARELY OCCASIONALLY OFTEN

18. HAVE YOU BEEN TOLD YOU HAVE GUM DISEASE? YES NO

HAVE YOU BEEN TREATED FOR GUM DISEASE? YES NO

19. DO YOUR JAW JOINTS EVER CLICK, POP, HURT, OR LOCK-UP? YES NO

HAVE YOU BEEN TREATED FOR "TMJ"? YES NO

20. WOULD YOU CONSIDER YOUR DAILY DIET TO BE: ___ GOOD ___ FAIR ___ POOR?

DO YOU EXERCISE REGULARLY? YES NO

21. HOW MUCH OF A PRIORITY IS IT TO KEEP YOUR NATURAL TEETH?

VERY HIGH SOMEWHAT HIGH LOW PRIORITY

22. HOW WOULD YOU RATE YOUR CURRENT DENTAL HEALTH?

PERFECT GOOD FAIR POOR HOPELESS

23. HOW DO YOU FEEL ABOUT VISITING OUR OFFICE TODAY?

EXCITED CONCERNED AFRAID TERRIFIED

24. IN WHAT AREAS WOULD YOU LIKE US TO ASSIST YOU? (PLEASE CHECK)

___ CLEANING YOUR TEETH

___ IDENTIFYING CURRENT PROBLEMS

___ IDENTIFYING ISSUES WHICH ARE LIKELY TO BE PROBLEMS IN THE NEAR FUTURE

___ WORKING WITH YOU TO CREATE LONG-RANGE STRATEGIES TO MAINTAIN THE HEALTH OF YOUR TEETH AND SMILE OVER YOUR LIFETIME

___ WORK WITH YOU TO IDENTIFY WAYS TO IMPROVE THE APPEARANCE OF YOUR TEETH/SMILE

25. EXCESSIVE STRESS CAN NEGATIVELY INFLUENCE ALL ASPECTS OF OUR HEALTH. WHAT DO YOU FEEL ARE THE BIGGEST SOURCES OF STRESS YOU ARE FACING TODAY?