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13231 CHAMPION FOREST DRIVE, SUITE #304
HOUSTON, TX 77069
281-444-2755

PATIENT INFORMATION

Name_____ Date_____
SS#_____ Date of Birth_____ Age_____
Address_____
City_____ State_____ Zip_____
Sex: Male____ Female_____ Single____ Married_____ Divorced_____ Separated_____ Widowed____
Occupation_____ Employer_____
Employer Address_____
City_____ State_____ Zip_____

Spouse's name_____ Date of Birth_____
SS#_____ Occupation_____ Employer_____

If a minor, Parent or Guardian's name _____ Date of Birth_____
SS#_____ Occupation_____ Employer_____

CONTACT INFORMATION

Home Phone_____ Work Phone_____ Cell Phone_____
Email address_____ Fax _____
Best time/place to reach you_____
Emergency contact (specify someone who does not live in your household)
Name_____ Relationship_____
Home Phone_____ Work Phone_____ Cell Phone_____
Please list all the people, and their relationship to you, that you may want us to discuss your condition or treatment with: _____

_____
Whom may we thank for referring you to our practice_____
Have we treated any of your friends or family? _____ Who?_____
Former dentist_____ City/State_____
Reasons for changing?_____
Date of last dental visit_____ Date of last dental x-rays_____
Have you ever had instructions on the care of your gums?_____
How often do you brush?_____ How often do you floss?_____
Do you follow a special diet_____
Brief outline of your typical day's diet:
Breakfast_____ Cups of coffee per day_____ Reg._____ Decaf_____
Lunch_____ Soft drinks per day_____
Dinner_____ Alcoholic drinks per day_____

DENTAL HISTORY *(please check all that apply)*

Bad breath _____	Bleeding gums _____	Blisters mouth/lip _____
Broken/lost fillings _____	Chew on one side _____	Clicking/popping jaw _____
Dry mouth _____	Fingernail biting _____	Food collects between teeth ____
Clench/grind teeth _____	Gums swollen/tender _____	Jaw pain/tiredness _____
Loose teeth _____	Mouth pain when brushing _____	Orthodontic treatment _____
Pain in ear area _____	Periodontal treatment _____	Sensitivity to cold _____
Sensitivity to heat _____	Sensitivity when chewing/biting _____	Sores/growths in mouth _____

Smoke _____ Cigarette _____ Cigar_____ Pipe_____ How long?_____ How much?_____
Dip Snuff or Chew Tobacco _____ How Long? _____ How Much?_____
Would you like to know what options are available to you to improve your smile? _____