



VIRAMONTES SMILE CARE
DENTAL HYGIENE PRACTICE

NEW PATIENT FORM

PATIENT INFORMATION

Full Name _____ Nickname _____
Date of Birth _____ Age _____ ☐ Male ☐ Female ☐ Other
Address _____ City _____ Zip _____
Phone _____ Email _____
Preferred Method of Contact ☐ Call ☐ Text ☐ Email

EMERGENCY CONTACT

Name _____ Relationship _____
Phone _____

DENTAL INFORMATION

Are you in pain today?	☐ Yes ☐ No	Are you happy with the appearance of your smile?	☐ Yes ☐ No
Do your gums bleed when brushing or flossing?	☐ Yes ☐ No	Are you interested in teeth whitening?	☐ Yes ☐ No
Do you have sensitive teeth?	☐ Yes ☐ No	Are you interested in improving the alignment of your teeth?	☐ Yes ☐ No
Do you have any loose or broken teeth?	☐ Yes ☐ No	Are you interested in learning more about periodontal (gum) health?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No	Do you have any cosmetic concerns?	☐ Yes ☐ No
Do you experience jaw pain, popping or clicking?	☐ Yes ☐ No	If yes, please explain _____	
Have you noticed any changes in your bite?	☐ Yes ☐ No		
Do you have dry mouth?	☐ Yes ☐ No		
Do you get cold sores?	☐ Yes ☐ No	What is your main reason for today's visit? _____	

DENTAL HISTORY

Date of last dental cleaning _____ Name of previous dental office _____
How often do you brush? _____ How often do you floss? _____
Do you use any other oral hygiene products? ☐ Water flosser ☐ Interdental brushes ☐ Mouthwash ☐ Other _____
What are your oral hygiene goals? _____

REFERRAL INFORMATION

How did you hear about us? ☐ Family/Friend ☐ Social Media ☐ Google ☐ Healthcare Provider ☐ Other _____
If referred, may we thank them by name? _____

INSURANCE / RESPONSIBLE PARTY (if applicable)

Primary Insurance _____ Subscriber Name _____
Subscriber Date of Birth _____ Relationship to Patient _____

ACKNOWLEDGMENT

I understand that the information I have provided is accurate and complete to the best of my knowledge. I will inform the office of any changes in my information.

Patient Signature _____ Date _____