COMPREHENSIVE
DENTAL CARE

Welcome to Comprehensive Dental Care!
Thank you for choosing our office to take care of all your dental needs. We appreciate your confidence and look forward to keeping your smile healthy for a lifetime!
So that we may provide you with the best possible care, please complete this medical/dental history form. All information is completely confidential.

Today's Date: _____

PATIENT INFORMATION

FIRST NAME: _____ LAST: _____ MIDDLE INITIAL: _____
DOB: ____/____/____ SS#: _____-_____-_____ Sex: Male: ☐ Female: ☐
Address: _____City: _____State: _____ Zip: _____
Cell:(_____) _____-_____ Work:(_____) _____-_____ Home:(_____) _____-_____
Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Separated: ☐
Email: _____
Employer: _____ Spouse's Employer_____
Employment Status: Full Time: ☐ Part Time: ☐ Retired: ☐ Student: ☐
IN CASE OF AN EMERGENCY CONTACT:
Emergency Contact: _____ Phone:(_____) _____-_____

DENTAL INSURANCE

Dental Insurance: Yes: ☐ No: ☐ Insurance Company_____
Relation to Subscriber: Self: ☐ Spouse: ☐ Dependent: ☐
If not self, Subscriber name: _____ DOB: ____/____/____
Employer: _____ Subscriber SS#: _____-_____-_____
Secondary Insurance: Yes: ☐ No: ☐ Insurance Company_____
Relation to Subscriber: Self: ☐ Spouse: ☐ Dependent: ☐
If not self, Subscriber name: _____ DOB: ____/____/____
Employer: _____ Subscriber SS#: _____-_____-_____

Assignment and Release:
I authorize release of any information relating to all dental claims and understand that I am responsible for all costs of dental treatment regardless of my insurance coverage. I hereby authorize payment of dental benefits otherwise payable to me directly to Vision Dental Partners Crown Point, LLC.
Signed_____Date: ____/____/____

DENTAL HISTORY

Reason for today's visit: Cleaning: ☐ Exam: ☐ Tooth Pain: ☐ Other: _____

How often do you brush? 1x/day: ☐ 2x/day: ☐ 3+/day: ☐ Never: ☐

How often do you floss? 1x/day: ☐ 1x/week: ☐ 1x/month: ☐ Never: ☐

Date of last dental visit: _____

Check the boxes if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips
- ☐ Burning sensation on tongue
- ☐ Chew on one side
- ☐ Cigarette/Pipe/Cigar smoking
- ☐ Clicking/Popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Swollen/Tender gums
- ☐ Jaw Pain/Tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/Growths in mouth

How did you hear about our office?

- ☐ Insurance
- ☐ Referral
- ☐ Radio
- ☐ Google/Internet
- ☐ Mail
- ☐ Other: _____