Welcome!

BRASS CITY DENTISTRY

New Patient Information

Patient's Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Physician/Medical Group Name: _____

Emergency Contact:_____ Relationship: _____

Phone Number: _____

Referred by: _____Friend _____Postcard _____Drive-by/Signage ____Internet ____ Other:_____

Insurance Information

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder:_____

DOB of Policy Holder:____/____/____

Employer:_____

How many years employed? _____

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder:_____

DOB of Policy Holder:____/____/____

Employer:_____

How many years employed? _____

Dental History

Date of last dental visit: _____ Dentist Name: _____

Were x-rays taken at the most recent last visit: ☐ Yes ☐ No

Please check Yes or No to any of the following conditions that apply to you/ your child:

Y N (Please Check)	Y N (Please Check)	Y N (Please Check)
☐☐ Problems Associated w/ Previous Dental Treatment	☐☐ Bleeding Gums	☐☐ Grinding or Clenching Teeth
☐☐ Tooth Pain (Currently)	☐☐ Earaches or Neck Pain	☐☐ Food/Floss Catches Between Teeth
☐☐ Serious Injury to Head/Mouth	☐☐ Sores or Ulcers in Mouth	☐☐ Clicking/Popping/Pain in Jaw
☐☐ Dry Mouth	☐☐ Finger/thumb-sucking habits	☐☐ Denture/ Partials
☐☐ Home Water Supply Fluoridated	☐☐ Previous periodontal (gum) treatment	
☐☐ Drinks Bottled or Filtered Water Exclusively	☐☐ Tooth/teeth sensitivity to cold, hot, and/or sweets	
☐☐ Mouth Breather	☐☐ Tooth/teeth sensitivity when chewing (pressure)	
☐☐ Previous Orthodontic (braces)Treatment	☐☐ Self-conscious/unhappy with appearance of teeth	

☐☐ Have any family members received orthodontic treatment? If yes, how did they feel about the result?

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