Patient Information

Welcome to Lamb Family Dental. We appreciate the confidence you have placed in us to provide your dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your overall health, please let us know. If you have questions, please do not hesitate to ask. Thank you.

Patient Name: _____ Date of Birth: _____Sex:_____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell: _____ SS #:_____

Can we contact you by email: ___Yes ___No Email Address:_____

Employer/ Occupation: _____ Bus. Phone: _____

In Case of Emergency- Name & Phone #:_____ Relationship: _____

In Case of Emergency #2(outside of household):_____ Relationship: _____

Primary Dental Insurance: _____ Phone #:_____

Subscriber's Name: _____ Subscriber #_____ SS#: _____

Group #:_____Date of Birth: ____/____/____ Patient Relationship to Subscriber: _____

Is patient covered by additional insurance? Yes _____ No_____ *If yes please ask for additional sheet

Primary Care Physician Name & Phone #:_____Date of last visit: _____

Previous Dentist Name & Phone #:_____ Date of last visit: _____

Referred to us by: _____ *So that we can happily credit account for their referral!

Dental History

Yes	No		Yes	No	
☐	☐	Are you apprehensive about dental treatment?			How often do you brush? _____
☐	☐	Have you had problems with previous dental treatment?			How often do you floss? _____
☐	☐	Have you ever experienced sedation dentistry?	☐	☐	Are you a habitual gum chewer?
☐	☐	Would you like to learn more about sedation dentistry?	☐	☐	Do you clench or grind your jaw frequently?
☐	☐	Are you aware of an uncomfortable bite?	☐	☐	Does your jaw ever feel tired?
☐	☐	Do you have a sensitive gag reflex?	☐	☐	Does your jaw make noise so it bothers you or others?
☐	☐	Do you wear dentures or removable appliances?	☐	☐	Does your jaw get stuck so that you can't open freely?
☐	☐	Does food get caught between your teeth?	☐	☐	Does it hurt when you chew or open wide to take a bite?
☐	☐	Do you have difficulty chewing your food?	☐	☐	Do you have earaches or pain in front of the ears?
☐	☐	Do you avoid brushing because of pain?	☐	☐	Do you have mouth pain or headaches upon awakening?
☐	☐	Do your gums bleed easily or when flossing?	☐	☐	Does pain or affect your daily activities?
☐	☐	Do your gums feel swollen or tender?	☐	☐	Does jaw pain or discomfort affect your appetite or sleep?
☐	☐	Have you received prior Periodontal treatment?	☐	☐	Do you suffer from recurring headaches?
☐	☐	Do you have slow healing sores in or around your mouth?	☐	☐	Do your headaches progress to migraines?
☐	☐	Are your teeth sensitive?	☐	☐	Do you have facial pain, cheeks, jaw, joints throat or neck?
*Do you feel pain when your teeth come in contact with			☐	☐	Do you take medications or pills for facial pain?
☐	☐	Hot or Cold Foods or liquids?	☐	☐	Do you have temporomandibular (jaw) disorder (TMD)?
☐	☐	Sweets?	☐	☐	Are you unable to open your mouth as far as you want?
☐	☐	Do you take a Fluoride supplement?	☐	☐	Have you had trauma to the jaw?
☐	☐	Have you ever received Orthodontic care?	☐	☐	Have you ever received Botox Therapy or Dermal Fillers?
☐	☐	Are you interested in Invisalign?	☐	☐	Would you like to learn about Botox or Dermal Fillers?
☐	☐	Do you have loose or missing teeth?	☐	☐	Are you happy with your smile?
☐	☐	Are you interested in Dental Implants?	☐	☐	Would you like to learn about Dental Crowns and Veneers?
☐	☐	Would you like to learn about teeth Whitening?	☐	☐	Do you want complete dental care?