

Clemson SC Dental Associates

PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.*

Patient's name _____ Preferred name _____ Birth date _____
If minor, parents names _____ Home phone _____ Work phone _____
Mailing address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____
Spouse's name _____ Spouse's employer _____ Unmarried
Whom may we thank for referring you to our office? _____
How did you find our office Phonebook Website Facebook Other _____

BILLING, CREDIT, AND INSURANCE INFORMATION: Not covered by dental insurance
Your Social Security number: _____ Dental Insurance Co. _____ Group number _____
Covered by spouse's insurance? yes no
Spouse's dental insurance company _____ Group number _____
Spouse's birthday _____ Social Security number _____

Patient Dental History

Reason for the visit _____
When was your last dental visit _____ What was done then _____
Have you had a complete Series of dental x-rays taken yes no When _____
Do your gums bleed while brushing or flossing? yes no
Are any of your teeth sensitive to hot or cold liquids/foods? yes no
Are any of your teeth sensitive to sweet or sour liquids/foods? yes no
Do you feel pain to any of your teeth? yes no
Have you had any head, neck or jaw injuries? yes no
Do you get migraines? yes no
Does food tend to get scaught between yout teeth? yes no
Have you had periodontal treatment (gum)? yes no
Do you wear a bite plate, night guard, or other appliance? yes no
Have you ever had orthodontic treatment? yes no
Do you wear dentures or partials? yes no
If you could change anything about your smile, what would you change? _____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is m responsibility to inform the dental office of any changes.

Signature of patient (or parent) _____ Date _____