EFD
ELLIS FAMILY DENTISTRY

PATIENT INFORMATION

Patient Name _____ Date _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security # _____ Birth Date: _____

Phone (Home): _____ (Work):_____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐Th ☐F

Address: _____
Street City State Zip Code

DENTAL INFORMATION

Date of Last Dental Visit: _____Reason for this visit: _____

When were your last x-rays taken? _____ How often do you visit the dentist? _____

Previous Dentist information (name, address, and telephone) _____

How often do you brush your teeth? _____ How often do you floss? _____

Is your water fluoridated? _____ yes _____ no

Do your gums bleed? _____ yes _____ no

Are your teeth sensitive? _____ yes _____ no

If yes, to what? ____hot ___cold ___pressure ___ sweets

Do any of your teeth hurt? _____ yes _____ no

Have you ever had any head, neck or jaw injuries? _____ yes _____ no

Have you ever experienced any of the following problems in your jaw?

Clicking _____ yes _____ no
Popping _____ yes _____ no
Jaw pain or soreness _____ yes _____ no
Muscle Pain _____ yes _____ no
Difficulty in opening or closing _____ yes _____ no
Difficulty in chewing _____ yes _____ no

Do you have frequent headaches, neckaches, or shoulder aches? _____ yes _____ no

Do you clench or grind your teeth? _____ yes _____ no

Have you ever had periodontal treatment? _____ yes _____ no

Have you had orthodontic treatment? _____ yes _____ no

Do you wear dentures or partials? _____ yes _____ no, If so, date of placement_____

Have you ever had any complications with previous dental treatment?

If yes, explain _____

Is there anything about dentistry you strongly dislike? _____

If you could change anything about your smile, what would you change? _____

Do you have any questions or concerns? _____