L'ESPLANADE DENTAL CENTRE

Personal Information:

Name: (Mr.)(Mrs.)(Ms)_____ I prefer to be called:_____ Gender: (M) (F)_____

Home address:_____ City: _____ Postal code:_____

Home phone number:_____ Business phone number:_____

Cell phone number:_____ E-mail address:_____

Date of birth (MM/DD/YY)_____ Occupation:_____

Dental Insurance:

Do you have Dental Insurance?_____ Insurance company:_____

Policy number:_____ Certificate number:_____

Name of policy holder:_____ Date of birth of policy holder:_____

Employer of policy holder:_____

Emergency Contact:

Name:_____ Phone number:_____

Name of physician:_____ Phone number:_____

Dental History:

Why have you come to the dentist today?_____

Many patients come for a second opinion. Have you seen another dentist for your dental needs?_____

How would you describe the condition of your teeth and gums? Good Fair Poor

Are you having discomfort or pain with your teeth and/or gums? Yes No

• If yes please explain:_____

Date of last dental visit? (MM/YY)_____ Previous dentist:_____

How often do you brush?_____ __ floss?_____ Do your gums bleed when you brush? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Have you ever been treated for T.M.D. (T.M.J.) Symptoms? Yes No

If you could wave a wand and change anything about your teeth or smile, what would it be?_____

If you could safely and easily whiten your teeth, would you be interested? Yes No

I, the undersigned, certify that the information I have provided is accurate and complete, and that I have not knowingly omitted any information.

I authorize the dentist to perform diagnostic procedures as may be required.

I understand that I am responsible for payment of all dental services performed in the office for myself and my dependents.

I have been advised of the privacy policy of the office and understand that it determines how personal information will be collected, used and disclosed within the guidelines of the policy.

Signature:_____ Date:_____