ASCENT
FAMILY DENTAL

Welcome

Name Date

Street Address

City State Zip

Cell Phone# Other Phone#

May we confirm your appointments by Text?

Email Address

DOB Marital Status

Social Security #

How did you find our practice?

Insurance Information

Primary Dental Insurance Employer

Insurance Co Address

Insurance Phone #

Group # ID #

Policy Owners Name

DOB Relationship to Patient

Social Security #

Secondary Dental Insurance Employer

Insurance Co Address

Insurance Phone #

Group # ID #

Policy Owners Name

DOB Relationship to Patient

Social Security #

Signature_____Date_____

Medical History

Are you now or have you recently been under a physician's care?
Yes ___ No ___ Reason_____

Physician's name Phone #

Check any of the following medical conditions you have or had:

___ Arthritis ___Hepatitis or Jaundice __ Prolonged bleeding

___ Headache/ Migraine ___ Liver Disease ___Fainting tendency

___ Heart trouble/Surgery ___ Cancer/ Tumor ___ Epilepsy

___ Jaw Pain ___ Tuberculosis ___ Thyroid Disease

___ High/Low Blood Pressure ___ Diabetes

___Chest Pain ____ Kidney/bladder trouble ___ Radiation treatment

___ Stroke ___Anemia ___ Mental Disorders

___ Shortness of breath ____Lung Disease ___ HIV or AIDS

___Asthma or Hay Fever ____Venereal Disease

___Prosthetic Joint Replacement ____Sinus Trouble ___ Glaucoma

___ Blood Disease ___ Blood Transfusion

List any Medications or supplements you are taking:

List anything you are allergic to:

Reactions to inexpensive jewelry? ____Yes _____No

Dental History

Date of last dental visit_____Cleaning_____

Why are you changing dentists_____

Any problems with past dental treatment? Please explain_____

Are you pleased with your smile? ___ Yes ___No

Do your gums bleed when your brush ___ Yes ___No

Would you like to remove and replace any silver fillings? ___ Yes ___No

Would you like whiter teeth? ___ Yes ___No

Would you like straighter teeth? ___ Yes ___No

Do you have any missing teeth? ___ Yes ___No

Are you interested in replacing any of your teeth? ___ Yes ___No

Would you like to repair chips in your teeth? ___ Yes ___No

Have your wisdom teeth been extracted? ___ Yes ___No

Do you clench or grind your teeth? ___ Yes ___No

Does dental treatment make you nervous? ___ Yes ___No

Check if you have the following habits.
____ Nail biting ____Thumb sucking ____ Mouth Breathing

What is your biggest dental concern today_____