WELCOME

Alfred Phen, DDS and Irene Kan, DMD

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ Patient's Date of Birth: _____

Patient's Address: _____ Patient's Social Security #: _____

_____ Email: _____

Telephone Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Patient's Age: _____ Sex: _____ Marital Satus: _____

Emergency Contact: _____ Phone #: _____

How may we contact you? (Please circle one) Home Phone, Cell Phone, Work Phone, Email, Text

HOW DID YOU HEAR ABOUT OUR OFFICE? *we like to thank those who refer to us.*

Internet ____ Insurance Company ____ Drive By ____ Facebook ____ Friend/Family ____

Other _____

RESPONSIBLE PARTY

Relationship to patient: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Phone #: _____

_____ Cell Phone#: _____

_____ Work Phone#: _____

DENTAL INFORMATION

How would you describe your current dental problem? _____

_____

How do you feel about the appearance of your teeth? _____

Do your gums bleed when you brush?	Yes	No
Are your teeth sensitive to heat or cold?	Yes	No
Do you grind or clench your teeth?	Yes	No
Are you having pain or discomfort at this time?	Yes	No
Do you have any teeth sensitive to pressure or sweets?	Yes	No
Have you ever had any trauma to your face or mouth?	Yes	No

Date of last dental examination _____ What was done at that time? _____

Former Dentist's Name: _____ City: _____