



WELCOME TO GLADURA DENTAL

Thank you for selecting our practice for your dental care! We would like to thank the person who referred you to us. Please write their name below. If you weren't referred to us by a patient, we would still like to know how you heard about us (Google/Bing/Yahoo search, Facebook/Twitter, Direct Mail, Physician, Outside Sign, Insurance website, or Other.)

Referred by

Patient Information

Date _____ Soc. Security # _____ DOB _____

Name _____ Preferred Name _____
Last Name First Name Initial

Address _____ Email _____

City _____ State/Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Primary Phone: Cell Home Work **Gender:** Male Female

Marital Status: Married Single Divorced Separated Widowed

Student: Y N If under 18, Parental Guardian's Name _____

Name of person responsible for account if different from patient _____

Address _____

City, State, Zip _____

Relationship _____ Best phone number _____

Address _____

Emergency contact _____
Name Best Phone Number Relationship

Dental Insurance

Primary Dental Insurance Company Subscriber's Name Subscriber's Soc Sec. #/ID#

Subscriber's Date of Birth Employer Group/Plan Number

Dental History

Do you require antibiotics before dental treatment? O Y O N

Are you currently in pain? O Y O N

Have you ever had gum treatment? O Y O N

Are you aware of popping, clicking, or snapping noises when you chew or open/close your mouth? O Y O N

Are you aware of grinding or clenching your teeth? O Y O N

Is there anything about your mouth that concerns you now? _____

Is there anything about your smile you would like to change? _____

How often do you brush? _____ Floss? _____

When was your last dental office visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Does food lodge between your teeth? _____

Do you feel you have unpleasant breath or taste in your mouth? _____

Are you aware of grinding or clenching your teeth? _____

Do you have headaches? _____

Signature of Patient, Guardian or Personal Representative

Date

Please print name of Patient, Guardian or Personal Representative

Date