BLACK CANYON DENTAL
We would like to get to know you better!

Name: Male ❑ Female ❑ Date:
Mailing Address: Zip Code:
If child; Parent name:
Phone: Cell _____ Emergency Contact _____
Email address: (for appointment reminders only)_____
Occupation: Employer: Employer Phone:
Date of Birth: Age: Spouse's Name:
Spouse's Occupation: Spouse's Employer:
Employer Phone: _____ Who referred you to our office?
Person responsible for dental investment:

For Insurance Purposes:
Name of Carrier:
Social Security Number: Group Number:
Are you covered by another plan? If so, Name of Carrier:
Social Security Number: Group Number:

……

Are your teeth sensitive to:	Yes	No
Heat?	❑	❑
Cold?	❑	❑
Sweets?	❑	❑
Biting Pressure?	❑	❑
Does food catch between your teeth?	❑	❑
Do your gums bleed when brushing?	❑	❑
Have you noticed any gum swelling around any teeth?	❑	❑
Do you have an unpleasant taste or odor in your mouth?	❑	❑

Problems of the Jaw:		
Clicking of the jaw	❑	❑
Clenching or Grinding	❑	❑
Pain (joints, ear, side of face)	❑	❑
Difficulty opening or closing	❑	❑
Difficulty chewing	❑	❑
Do you ever avoid any part of the mouth while brushing?	❑	❑
Have you had a reaction to a local anesthetic?	❑	❑
Are you dissatisfied with your teeth & their appearance?	❑	❑
Are you deeply concerned about the finances required to return your teeth to excellent dental health?	❑	❑
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	❑	❑
Do you smoke?	❑	❑
Have you ever had any teeth removed?	❑	❑
How long have these teeth been missing?		

When was your last dental appointment?	Yes	No
Do you have any general health problems?	❑	❑
If so, please specify:		
Have you had surgery?	❑	❑
If so, please specify:		
Are you currently under a physician's care?	❑	❑
Reason:		
Any Medications—please list		

_____

To the best of your knowledge, are you or have you ever been afflicted with:		
Sleep Apnea	❑	❑
Heart Ailment	❑	❑
Diabetes	❑	❑
Rheumatic Fever	❑	❑
Epilepsy	❑	❑
High Blood Pressure	❑	❑
Respiratory Disease	❑	❑
Hepatitis A B C (please circle one)	❑	❑
HIV Positive	❑	❑
Prolonged Bleeding	❑	❑
Healing Complications	❑	❑
Allergy to any Drug _____	❑	❑
Are you pregnant?	❑	❑

Why did you leave your last dentist_____
_____

Do you feel you will eventually wear artificial dentures? ❑ ❑

Do you have any fears? ❑ ❑

What is your present dental problem? _____

_____

Signature: