**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 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you to our office?

Person responsible for dental investment:

For Insurance Purposes:

Primary Insurance Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Pt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:

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 When was your last dental appointment? Yes No

Heat or Cold? ❑ ❑ Do you have any general health problems? ❑ ❑

Sweets? ❑ ❑ If so, please specify:

Biting Pressure? ❑ ❑ ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does food catch between your teeth? ❑ ❑ Have you had surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ ❑

Do your gums bleed when brushing? ❑ ❑ If so, please specify:

Problems of the Jaw: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clicking of the jaw ❑ ❑ Are you currently under a physician’s care? ❑ ❑

Clenching or Grinding ❑ ❑ Reason(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain (joints, ear, side of face ❑ ❑ Any Medications—please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Difficulty opening or closing ❑ ❑ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty chewing ❑ ❑ To the best of your knowledge, are you or have you ever

Do you ever avoid any part of the mouth while brushing? ❑ ❑ been afflicted with:

Have you had a reaction to a local anesthetic? ❑ ❑ Sleep Apnea ❑ ❑

Are you dissatisfied with your teeth & their appearance? ❑ ❑ Heart Ailment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ ❑

Are you deeply concerned about the finances required to Diabetes ❑ ❑

return your teeth to excellent dental health? ❑ ❑ Rheumatic Fever ❑ ❑

Do you get frustrated because you always have something Epilepsy ❑ ❑

to be treated or repaired when you visit a dentist? ❑ ❑ High Blood Pressure ❑ ❑

Do you smoke or use tobacco (please circle) ❑ ❑ Respiratory Disease ❑ ❑

Do you use any cannabis, medically or recreationally? ❑ ❑ Healing Complications ❑ ❑

In what form? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis A B C (please circle one) ❑ ❑

Have you ever had any teeth removed? ❑ ❑ HIV Positive ❑ ❑

How long have these teeth been missing? Prolonged Bleeding ❑ ❑

Do you feel you will eventually wear artificial dentures? ❑ ❑ Allergy to any Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ ❑

Do you have any dental fears? ❑ ❑ Are you pregnant? ❑ ❑

What is your present dental problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_