Dental Patient Information Form

Patient Information

- **Full Name: _____**
- **Date of Birth: _____**
- **Address: _____**
- **Phone Number: _____**
- **Email Address: _____**

Dental History

1. **Do you have any dental concerns?**

   _____

2. **Date of Last Dental Visit: _____**
3. **Do you have any dental appliances (e.g., dentures, bridges)?**

   ☐ Yes ☐ No

   If yes, please specify: _____
4. **Are you experiencing any of the following? (Check all that apply)**

   ☐ Tooth Pain

   ☐ Bleeding Gums

   ☐ Sensitivity to Cold/Hot

   ☐ Jaw Pain

Dental Insurance Information

- **Insurance Provider: _____**
- **Policy Number: _____**
- **Group Number: _____**
- **Employer: _____**

Signature

I confirm that the above information is accurate to the best of my knowledge.

Patient Signature: _____ Date: //_____