BLUE DIAMOND DENTAL, P.A. – Vincent J. Daniels, DMD

Dental and Oral Health Information

Patient's name: ____ Date of birth: ________Date:_________
Address: ______________________________ City_____________ State_______ Zip__________
Email: ________________________________ Home Phone_______________ Cell Phone_______________
If Student, Name of School/College___________________________________
Patient or Parent/Guardian's Employer _________________________________Work Phone________________
Spouse or Parent/Guardian's Name ____________________Employer ____________Work Phone___________
Who May We Thank for Referring You? ____

Insurance Information

Name of Insured____ Relationship to Patient________________
Birthdate _______________________ SS# ___________________ Date Employed_____________________
Name of Employer ______________________ Union of Local# _______________Work Phone____________
Address of Employer_______________________City_____________________State___________ Zip________
Insurance Company _______________________ Group#__________________ Policy ID#_________________
Ins. Co. Address__________________________ City_____________________ State__________ Zip________

If you are a NEW Patient to this practice:
Date of last dental visit_________ Dentist's Name______________________ City & State_______________

Please describe any specific dental problem or discomfort you having at this time: ________________________
____ How long has it been present: ___________

Do you have/ have you had/ have you noticed any of the following signs or symptoms in your head, neck, or mouth? (please check Yes or No for each question)

	Yes	No		Yes	No
Teeth that are sensitive to			Sores, ulcers, or rough spots in your mouth	___	___
Hot, cold, sweets, or biting pressure	___	___	Do you wear dentures or partials	___	___
An unpleasant taste or persistent bad breath	___	___	Do you feel pain in any of your teeth	___	___
Do your gums bleed when brushing	___	___	Have you ever bleached your teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Do you have frequent headaches	___	___
Clench or grind your teeth	___	___	Any lumps, swelling or swollen glands	___	___
Difficulty opening or moving the jaws	___	___	Pain, tenderness, numbness, or earaches	___	___
Clicking, snapping, difficulty chewing					

Your Dental Health:
How do you rate your overall dental health? ____ Good ____ Fair ____ Poor

Have you ever had any complications from an extraction or dental treatment? ____ Yes ____ No

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth? ___Yes___ No