BRIDGENORTH DENTAL CLINIC
DR. JOHN LYNE PROFESSIONAL DENTISTRY CORPORATION

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ EMAIL _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ AGE _____ SEX _____ _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU _____

INSURANCE INFORMATION

NAME OF INSURED _____ DATE OF BIRTH _____ I.D./S.I.N. _____

EMPLOYER/GROUP POLICY HOLDER _____ INSURANCE COMPANY _____

GROUP/INDIVIDUAL POLICY # _____ CERTIFICATE # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ **YES** ☐ **NO** **IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED _____ DATE OF BIRTH _____

EMPLOYER/GROUP POLICY HOLDER _____ INSURANCE COMPANY _____

GROUP/INDIVIDUAL POLICY # _____ CERTIFICATE # _____

PATIENT DENTAL HISTORY

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT, COLD OR SWEET LIQUIDS/FOODS	☐	☐
DO YOU HAVE ANY JAW JOINT PROBLEMS	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐

	YES	NO
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
WOULD YOU CONSIDER YOURSELF A NERVOUS DENTAL PATIENT	☐	☐
HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE	☐	☐
HAVE YOU EVER RECEIVED NITROUS OXIDE (LAUGHING GAS) DURING DENTAL TREATMENT	☐	☐
DO YOU HAVE ANY CONCERNS ABOUT YOUR TEETH/MOUTH	☐	☐
DO YOU HAVE ANY SPECIFIC QUESTIONS YOU WISH TO ASK THE DENTIST/HYGENIST	☐	☐