Badlands Dental

Please fill out this form completely. It is important to your dental care. Our goal is to help you reach andmaintain good oral health.

About you:

Date:_____

Name:_____ Preferred name: _____ Male ___ Female___
Last First Middle initial

___Married ___Single ___Partnered ___Divorced ___ Widowed

Birthdate:_____ SSN#: _____

Home Address: _____
Street City State Zip

Home #: _____ Cell #: _____ Work #: _____

E mail:_____

Preferred contact method / confirm appointments: text call email

Employer: _____ Employer address: _____
City State Zip

Occupation: _____ How Long there? _____

Person Responsible for Account if other than yourself:

Name: _____ Birthdate: _____ SSN#: _____

Employer: _____ Work:_____ Cell #:_____

Primary Dental Insurance Information:

Primary Policy Holder Name:_____ DOB: _____

Policy Holder SS#:_____

Subscriber ID:_____Group number:_____

Insured's Employer:_____Insurance Company:_____

Insurance CO Address:_____

Badlands Dental, P.C.

Dental History

What is the reason for your visit today? _____

Name / Location of your last dentist: _____

Date of last dentist visit: _____ Date of last full mouth x rays: _____

Do you wear any dental prosthesis or appliance, such as a denture, partial or night guard retainer?

__ Y __N

Are you happy with your prosthesis/appliance ? __Y __N

Why? _____

Would you like to know more about permanent replacements? __ Y __N

Are you apprehensive about dental treatment? __Y __N

Have you had any periodontal (gum) treatment? __Y __N What kind? _____

Do your gums bleed or feel tender or irritated? __Y __N

Are your teeth sensitive to hot, cold, sweets, or pressure? __Y __N

Are you happy with the appearance of your teeth? __Y __N Why not? _____

Do you clench or grind your teeth? __Y __N

Do you have headaches, earaches, or neck pain? __Y __N

Do you have discolored teeth that bother you? __Y __N

Would you like your smile to look better or different? __Y __N