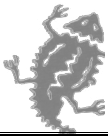

WELCOME TO DR. WALKER'S OFFICE

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

PATIENT INFORMATION

Date ______________

Patient name ________________________________ SS#____

Address ____________________________________ Occupation ______________________________________

City ____ Patient employer/school ____________________________

State ___________Zip Code ___________________ Spouse's/Parent(s) Name(s) ________________________

Sex ☐ M ☐ F Age______ Birthdate _______________ Spouse's Employer _________________________________

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Partnered Whom may we thank for referring you?___________________

CONTACT INFORMATION

Primary Contact #: ___________________________ Cell Home Work (Circle one) **TEXT opt in**: ☐ Yes ☐ No

E-mail ____________________________________ **Email opt in**: ☐ Yes ☐ No

IN CASE OF EMERGENCY, CONTACT:

Name ______________________________ Relationship ________________ Primary contact #:__________________

DENTAL INSURANCE

Subscriber's Name ___________________________ Is Patient covered by Secondary Insurance ☐ Yes ☐ No

Relationship to Patient ________________________ Subscriber's Name __________________________________

Birthdate ___________ Member# ________________ Relationship to Patient ______________________________

Insurance Co________________________________ Birthdate _________________Member #______________

Group # ______________Phone # _____________ Insurance Co ____

Group # ________________Phone #_________________

DENTAL HISTORY

Reason for today's visit ____

Former Dentist _____________________	Would you describe your present dental health as good?	☐ Yes ☐ No
City State _________________________	Do you think you have active decay or gum disease?	☐ Yes ☐ No
Date of last dental visit ______________	Do you feel nervous about having dental treatment?	☐ Yes ☐ No
Date of last dental x-rays ____________	Have you ever had a bad experience in a dental office?	☐ Yes ☐ No
How often do you floss? _____________	Do you want to keep your remaining teeth?	☐ Yes ☐ No
How often do you brush? ____________	Do you like your smile? Why?___________________________	☐ Yes ☐ No
	Have you ever had orthodontic treatment?	☐ Yes ☐ No

Please check "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Mouth pain	☐ Yes ☐ No
Blisters on lips or in mouth	☐ Yes ☐ No	Oral cancer (date________________)	☐ Yes ☐ No
Loose teeth or broken fillings	☐ Yes ☐ No	Pain or ringing in/around the ear	☐ Yes ☐ No
Clicking or popping jaw (TMJ)	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Food collection between the teeth	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Grind or brux your teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Jaw pain or tiredness	☐ Yes ☐ No	Snoring	☐ Yes ☐ No
Lip or cheek biting	☐ Yes ☐ No		