Mill Creek Dental
Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: ____ Date of birth: ________________
Gender: ______________ Age: _______
Home address: ____
City: ___________________________ State: _______ Zip: ________________
Who may we thank for referring you? ____

Billing address (if different): ____
City: ____________________ State: _______ Zip: ________________

Home phone: ___________________________ Cell: ___________________________
E-mail: ____
SS #: ____________________________________ Employer/Occupation: ____________________________

Spouse's name ______________________________________ Phone Number: ___________________________

Primary dental insurance: ______________________________________ Group #: _______________________________
Policy Holder: ____ Date of Birth: ________________________________
Subscriber ID: __________________________________

Secondary dental insurance: ______________________________________ Group #: _____________________________
Policy Holder: ____ Date of Birth: ________________________________
Subscriber ID: __________________________________

Name of your medical doctor: ____

Dental History

Y N Are you apprehensive about dental care?
Y N Have you had problems with previous treatment?
Y N Do you gag easily
Y N Do you wear dentures?
Y N Does food catch between your teeth?
Y N Do you have difficulty chewing your food?
Y N Do you avoid brushing any part of your mouth?
Y N Do your gums bleed easily?
Y N Do your gums feel swollen or tender?
Y N Have you noticed slow-healing sores in your mouth?
Y N Are your teeth sensitive?
Y N Do you feel pain when your teeth come in contact with:
____ Hot foods or liquids
____ Cold foods or liquids
____ Sour foods
____ Sweets
Y N Do you take fluoride supplements?

Y N Are you dissatisfied with the appearance of your teeth?
Y N Does your jaw make noise that bothers you or others?
Y N Do you clench or grind your jaws frequently?
Y N Does your jaw get stuck so that you can't open freely?
Y N Does it hurt when you chew or open wide to take a bite?
Y N Do you have earaches or pain in front of the ears?
Y N Do you have any jaw symptoms or headaches after waking?
Y N Do you take medications or pills for pain or discomfort?
Y N Do you have a tempromandibular (jaw) disorder?
Y N Do you have pain in the face, cheeks, jaws, joints, throat or temples?
Y N Are you unable to open your mouth as far as you want?
Y N Are you aware of an uncomfortable bite?
Y N Have you had a blow to the jaw (trauma)?
Y N Are you a habitual gum chewer?
Y N Have you had orthodontics/Braces?
Y N Do you have your wisdom teeth?