Patient Health Record

Date: _____

Name: _____
(Last) (First) (Middle Initial) (Preferred Name)

Address: _____
(Street) (City, State) (Zip Code)

Date of Birth: _____ Social Security #_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address: _____

Do you prefer TEXT, EMAIL, or BOTH? (Please circle one)

Marital Status: (Circle One) Married Single Spouse's Name:_____

Your Employer: _____ Occupation: _____

Insurance Company: _____

Insurer's Name: _____DOB: _____

Insurer's Social: _____Employer: _____

Referred by: _____

Dental Health

When was your last teeth cleaning? _____

Have you had any serious problems with dental treatment? Please explain if so:

Are you having any pain/problems at this time? _____

Have you ever been diagnosed with Periodontal (gum) disease? _____

Are you having any TMJ problems (popping, clicking or pain in the jaw muscle? **YES** **NO**

_____

Have you lost any teeth **YES** **NO** If yes, when?_____

What are your goals for your mouth, teeth, smile? _____

What are your expectations of me (Dr. Flahaven) as your clinician? _____

_____

Why did you leave your last dentist? _____