*Treating patients like family for **over 40 years**!*
Our goal is to help you reach and maintain your maximum oral health
Please fill out this form completely.
The better we communicate, the better we can care for you!

Passes Dental Care

415 Northern Boulevard, Great Neck, NY, 11021
Tel: 516.487.3131 • Fax: 516-487-9391• www.passesdentalcare.com

ABOUT YOU

Name: _____

I prefer to be called: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
Work #:_____ Ext.___ Home #:_____
Billing Address: _____
_____
Relation: _____ Birthdate: _____

SPOUSE INFORMATION ♥

His/Her Name:_____
Home #:_____ Birthdate:_____
In an event of an emergency, is there someone who lives near you that we should contact?
His/Her Name: _____
Relationship to Patient: _____
Work #:_____ Home #:_____

Welcome to Our Dental Family!

DENTAL HISTORY

Why have you come to the dentist today?
_____
_____
_____
_____
_____

Do you require antibiotics before dental treatment?
☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work?
☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

I have a fear of/ I have concerns about:
☐ Experiencing Pain ☐ Needles ☐ Gagging
☐ Being Embarrassed ☐ Losing my teeth/False teeth

To understand what is going on in my mouth, My preference is:
☐ To know all the details
☐ To be given the bottom line
☐ To read pamphlets
☐ To talk with a team member about solutions to my problems

Do you now have or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
☐ Yes ☐ No

Your current dental health:
☐ Good ☐ Fair ☐ Poor

How many times a week do you floss?
_____

Do your gums ever bleed?
☐ Yes ☐ No

Type of bristles:
☐ Hard ☐ Medium ☐ Soft