DENTAL POINT

PATIENT INFORMATION FORM

Patient Information:

Full Name: _____ Date of Birth: _____
Address: _____ Phone: _____
Email: _____ Preferred Method of Contact: _____

Emergency Contact:

Full Name: _____ Relationship: _____
Phone: _____ Alternate Phone: _____

Dental Information:

1. Reason for Your Visit: _____
2. Date of Last Dental Visit: _____ Previous Dentist: _____
3. Are You Currently Experiencing Any Dental Pain or Discomfort? _____
4. Have You Ever Experienced a Dental Emergency? If Yes, Please Describe: _____
5. Are You Nervous or Anxious About Visiting the Dentist? _____
6. Have You Ever Had a Bad Reaction to Local Anesthesia? _____
7. Do You Have Any Questions or Concerns About Your Dental Health? _____

Health Information:

1. Are You Currently Under a Physician's Care? If Yes, Please Specify: _____

2. Do You Have Any Chronic Health Conditions or Allergies? If Yes, Please Specify: __

3. Are You Taking Any Prescription or Over-the-Counter Medications? If Yes, Please List:

4. Have You Had Any Surgeries or Hospitalizations in the Last Year? If Yes, Please Specify:

By signing below, I confirm that the information provided is accurate to the best of my knowledge. I understand that this information will be used to provide me with the best possible dental care.

Signature: _____ Date: _____

Please complete this form before your appointment and bring it with you to the dental office. This information will help us provide you with the best possible care and ensure that your dental treatment is tailored to your specific needs.