CITY DENTAL CENTER

Implant • Cosmetic • Sedation • General Dentistry

NEW PATIENT INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Master ☐

Full Name _____
Last Name First Name Middle Name

Date of Birth _____Home Phone #_____Cell # _____
Day/Month/Year

Home Address_____
Street No. Street Name Apt. No.

_____
City, Province Postal Code

Occupation _____ Business Phone #_____

In Case of Emergency, please contact: _____

Email Address_____

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet) ☐
- Tooth pain or discomfort when chewing ☐
- Headaches, earaches, neck pain ☐
- Jaw joint pain ☐
- Teeth or fillings breaking ☐
- Grinding or clenching teeth ☐
- Bleeding, swollen or irritated gums ☐
- Loose, tipped or shifting teeth ☐
- Bad breath or bad taste in your mouth ☐

Do you have or have you had any of the fo1lowing:

- Dentures ☐
- Partial dentures ☐
- Braces ☐
- Periodontal (gum) treatments ☐

Please share the following dates:

- Your last cleaning ____/____
- Your last oral cancer screening ____/____
- Your last complete x-rays ____/____

Name of Previous Dentist:

_____

Phone: _____

Why did you leave your previous dentist?

_____

If I could whiten my teeth for a cost anyone could afford, would I do it? ☐

I smoke or use chewing tobacco. ☐

If I could change my smile, I would:

- Make my teeth brighter ☐
- Make my teeth straighter ☐
- Close spaces ☐
- Replace black metal fillings with natural, tooth coloured fillings ☐
- Repair chipped teeth ☐
- Replace missing teeth ☐
- Replace old crowns that don't match ☐
- Have a smile makeover ☐

On a scale of 1 - 10, with 10 being the highest rating: How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile, dental health and the way we serve you?

_____

What is the most important thing to you about your dental visit today?

_____