James River Dentistry We would like to get to know you better!

Date	Home Phone			Cell Phone					
	Email Addre								
Patient's Nar	me								
	Last		First		Preferred				
			•				_		
Sex: M	_ F Birt	hdate			SS#				
Occupation_					Address				
Employer					Work Phone				
Spouse's nan	ameOccup		Occupation	ionEmployer					
Address	ess			Work Phone					
Person respon	nsible for dental investm	ent							
*****	*******	*****	******	******	********	******	*****	******	
Dental In	surance								
Name of carr	rier								
Name of carrierSocial Security #									
	ered by another plan?				·P "				
•	of carrier								
	ity # **********			•	p #				
Dental Hi		****	*****	*****	· · · · · · · · · · · · · · · · · · ·	· * * * * * * * * * * * * * * * * * * *	*****	****	
Dentai III	istor y						Yes	No	
	present dental problem?			Have vo	ou ever had a reaction	on to			
				-	local anesthetic?				
When was your last dental appointment?				Are you	dissatisfied with you and their appearan				
		Yes	No	Are you	deeply concerned a	about the			
Are your teeth	n sensitive to: Heat?				finances required to your mouth to exc				
	Cold?				dental health?				
	Sweets?			Do you					
	Biting?				ou ever had teeth ren ow long have these				
Does food cate	ch between your teeth?			11 903, 11	been missing?	teetii			
	s bleed when brushing?			Do you	feel you will eventu				
	ced swelling around			D	artificial dentures?				
	teeth?				have any dental fea I you leave your las				
	nn unpleasant taste or in your mouth?			willy die	i you leave your las	t delitist:			
	void any part of the								
mouth while brushing?				Who referred you to our office?					
				,, 110 101					
				D-4-					
Signature				Date					