Adult Form

Sunny Smiles Pediatric and Family Dentistry

We are pleased that you have chosen "Sunny Smiles" for your dental care. We take pride in providing quality dental care to you and your family.

Name: ____Date:________________

Date of Birth: _____/_____/_____ Gender/Sex: Male_____ Female______

Address: ____
Street
____
City State Zip

Home Phone: ________________ Cell Phone: _______________________

E-Mail: _________________________ SS#: _______/_____/_______

Dental Insurance Provider: ___________________________________

Member ID Number: _______________________________________

Group #: ____

How did you hear about our office? _______________________________

Dental Health Information

YES	NO	
___	___	Do your gums bleed when your brush or floss?
___	___	Are you teeth sensitive to cold, hot, sweets or pressure? __________________
___	___	Is your mouth often dry?
___	___	Do you wear dentures or partials?
___	___	Do you grind, or brux your teeth?
___	___	Do you have ulcers or sores in your mouth? __________________________
___	___	Do you have any clicking, popping or discomfort in the jaw?
___	___	Have you had any serious trauma to your head or mouth?
___	___	Have you had any periodontal(gum) treatments?
___	___	Have you ever had orthodontic(braces) treatments?
___	___	Have you had any problems associated with previous dental treatments?
___	___	Are you currently experiencing dental discomfort? ______________________
___	___	What is the reason for your dental visit today? _________________________ ____
___	___	Date of your last dental exam: ______________________