Pillager Dental

Patient Information

Patient Name:(First)_____ (MI)_____(Last)_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Male _____ Female_____ Social Security Number_____

Responsible Party _____

Home Phone _____Cell _____Email_____

Emergency contact _____Phone _____

Former Dentist _____ Date of last visit _____

Reason for visit today _____

Please Circle

Bad Breath	Y N	Bleeding gums	Y N
Chew on one side	Y N	Cigarette, pipe or cigar smoking	Y N
Clicking or popping of jaw	Y N	Dry mouth	Y N
Fingernail biting	Y N	Jaw pain or tiredness	Y N
Grinding of teeth	Y N	Loose teeth or fillings	Y N
Lip or cheek biting	Y N	Mouth breathing	Y N
Mouth pain while brushing	Y N	Pain around ear	Y N
Orthodontic treatment	Y N	Sensitivity to sweets	Y N
Sensitivity when biting	Y N	Sensitive to heat	Y N
Sensitive to cold	Y N	Swollen gums	Y N
Periodontal treatment	Y N	How often do you brush? _____ Floss? _____	

In this office we use local anesthetic and other methods of pain control to make our patients more comfortable while receiving treatment. Before treatment can be rendered, adequate radiographs of the teeth and mouth are needed. This is to certify that I, understand and consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general anesthetic as indicated and I will assume responsibility for gees and finance charges associated with those procedures.

Signature: _____Date: _____

Patient, parent or guardian

By signing you are also acknowledging that you are aware of the summary of Pillager Dentals notice of Privacy Practices Dated 10/19/15