DR:_____ APPT. DATE:_____ TIME:_____

NAME: _____ DATE:_____

PHONE:_____ ALT:_____

E-MAIL:_____

Who may we thank for referring you?_____

What is your chief concern for seeing us? _____

EOV TRIAGE

Area: UR_____ UL _____ LR_____ LL_____

How long have you had discomfort in this area? _____

Does it wake you at night**?** _____

Are you taking any medication?_____

NEW PATIENT

1. Do you have any family members that are patients?_____
2. Tell me about your previous dentist? May we request x-rays?_____

   Name of DDS_____ Phone #:_____

   When was your last dental hygiene visit? _____

   Do you know the last time you had x-rays taken?_____
3. Do you have allergies to medication or anesthesia?_____
4. Is it necessary that you PRE-MEDICATE prior to dental treatment?_____
5. Are you covered with dental insurance? _____
6. Are you familiar with our location?

ADVISE: PT. SHOULD ARRIVE A FEW MINUTES PRIOR TO APPOINTMENT TIME. PT. SHOULD GIVE AT LEAST 24 HRS. TO CANCEL OR RESCHEDULE

XRAYS ARE HERE _____TAKE XRAYS _____