Gary S. Hongo, DMD

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PATIENT: ____________ (LAST) ____________ (FIRST) ____________ (M.I.) ______

Sex F____ M____ Marital Status______________ Birthday___________ SS#______________________

Address: ______________________________ City____________________ State______ Zip Code _______

E-Mail:______________________________

Phone: Home_________________ Work__________________ Ext______ Cell______________________

RESPONSIBLE PARTY (if patient under 18) ____________ (LAST) ____________ (FIRST) ____________ (M.I.) ______

Sex F____ M____ Marital Status______________ Birthday___________ SS#______________________

Address: ______________________________ City____________________ State______ Zip Code _______

E-Mail:______________________________

Phone: Home_________________ Work__________________ Ext______ Cell______________________

EMERGENCY CONTACT: MUST BE FILLED OUT

Name:____ Relationship to patient_______________

Home Phone:______________________________ Work Phone:______________________________

REFERRAL: Name of person referring you here:______________________________ Relationship to patient: ____________

How else were you referred to our office? ____

DENTAL INSURANCE

DENTAL PRIMARY CARRIER

Employee's Name: ______________________________

Date of Birth:_______________ SS#____________________

Employer: ______________________________

Insurance Co. Name:______________________________

Address: ______________________________

Phone: ______________________________

Group/Local#:______________________________

Insured's Relationship to patient: ____________________

DENTAL SECONDARY CARRIER

Employee's Name: ______________________________

Date of Birth:_______________ SS#____________________

Employer: ______________________________

Insurance Co. Name:______________________________

Address: ______________________________

Phone: ______________________________

Group/Local#:______________________________

Insured's Relationship to patient: ____________________

DENTAL HISTORY

Reason for today's visit: ______________________________

Previous dentist's name: ______________________________

City/State:________________________ Phone: _______________

Date last treated:____________________ Last X-ray date: _________

(Please check if YES...comment space below)

- ☐ Orthodontic Treatment? (Braces) Year:__________
- ☐ Oral Surgery? (Extractions) Year:__________
- ☐ Periodontal (Gum) Treatment? Year:__________
- ☐ Your bite adjusted? Year:__________
- ☐ Are any teeth loose?
- ☐ Does food get caught between your teeth?

JAW PROBLEMS

- ☐ Pain (joint, ear, side of face)?
- ☐ Difficulty chewing?
- ☐ Difficulty opening & closing?
- ☐ Clicking of jaw?

HABITS: DO YOU...

- ☐ Clench or grind your teeth while awake or asleep?
- ☐ Bite your lips or cheeks regularly?
- ☐ Hold foreign objects with your teeth? (pencils, pins, nails, fingernails)
- ☐ Children: Dental development concerns?
- ☐ Is it important to you to keep your teeth?
- ☐ Are you satisfied with the appearance of your teeth?

Please explain YES answers or other concerns in this space:

____

Signature____ Date____________________