Patient Information

Mark P. Tompkins, DDS,
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19109 West Catawba Avenue • Suite 108
Cornelius, NC 28031
704/895-3833

Date _____

Patient's Name _____ ❑ Male ❑ Female
FIRST MIDDLE LAST NICKNAME

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Shift _____ Birthdate _____

Email Address: _____

If a child, give Parent's or Guardian's Name _____ SS# _____

School _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
FIRST MIDDLE LAST

Address _____ Birthdate _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Shift _____ SS# _____

Employer _____ Occupation _____ No. Years Employed _____

SPOUSE'S NAME _____

Address _____ Birthdate _____
FIRST MIDDLE LAST

Home Phone _____ Work Phone _____ Shift _____ SS# _____

Employer _____ Occupation _____ No. Years Employed _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's SS# _____
FIRST MIDDLE LAST

Dental Insurance
Company Name _____ Group # _____ Local # _____

Dental Insurance
Company Address _____
STREET CITY STATE ZIP

Marriage _____ Employment _____ Dental Insurance _____

Insured's
Employer _____ Address _____ Phone _____

Do your have double coverage? ❑ No ❑ Yes If yes, complete the following:

Insured's Name _____ Insured's SS# _____
FIRST MIDDLE LAST

Dental Insurance
Company Name _____ Group # _____ Local # _____

Dental Insurance
Company Address _____
STREET CITY STATE ZIP

Date of Employment _____ Dental Insurance _____

Insured's
Employer _____ Address _____ Phone _____

EMERGENCY NOTIFICATION INFORMATION In case of emergency, who should be notified?

Name _____ Address _____ Phone _____ Relation _____

Name _____ Address _____ Phone _____ Relation _____

To the best of my knowledge, all of the preceding answers are true and correct. I will inform your office of any changes at the next appointment.

_____
SIGNATURE OF PATIENT OR PARENT OR GUARDIAN DATE

– over –

Dental Questionnaire

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Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. What is your major dental concern? _____

2. Are you having any discomfort at this time? ❑ Yes ❑ No

3. Have you ever had any serious trouble associated with previous dentistry? ❑ Yes ❑ No

4. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

5. Date of last dental visit? _____

6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ❑ Yes ❑ No

7. How often do you brush? _____ Brush is: ❑ Soft ❑ Medium ❑ Hard

8. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	❑ Yes ❑ No
Unpleasant taste/bad breath	❑ Yes ❑ No
Burning tongue/lips	❑ Yes ❑ No
Frequent blister, lips/mouth	❑ Yes ❑ No
Swelling/lumps in mouth	❑ Yes ❑ No
Ortho treatments (braces)	❑ Yes ❑ No
Biting cheeks/lips	❑ Yes ❑ No
Clicking/popping jaw	❑ Yes ❑ No
Difficulty opening or closing jaw	❑ Yes ❑ No
Snoring, gasping	❑ Yes ❑ No

TEETH

Loose teeth	❑ Yes ❑ No
Sensitive to hot	❑ Yes ❑ No
Sensitive to cold	❑ Yes ❑ No
Sensitive to sweets	❑ Yes ❑ No
Sensitive to biting	❑ Yes ❑ No
Food impaction	❑ Yes ❑ No
Clenching/grinding	❑ Yes ❑ No
If so, when	_____
Shifting in bite	❑ Yes ❑ No
Change in bite	❑ Yes ❑ No
Headaches	❑ Yes ❑ No

9. Do you use the following?

Brush	❑ Yes ❑ No
Fluoride rinse	❑ Yes ❑ No
Dental floss	❑ Yes ❑ No
❑ Other	_____

10. Are you happy with the appearance of your teeth? ❑ Yes ❑ No

If not, why? _____

11. These are the things that are important to me about my dental health:

_____

12. What do you fear most about dental care? _____

13. Circle one:

A. My mouth is:
   a) Very comfortable
   b) Moderately comfortable
   c) Uncomfortable

B. I: a) Will do anything to keep my natural teeth
   b) Want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them

C: I: a) Have set goals for my oral health with a previous dentist
   b) Want to set goals concerning my dental health

D. I: a) Have always done the best that was recommended for my dental health
   b) Have not done what dentists have recommended to me
   c) Rarely go, and don't care much about having my dental work completed

E. I: a) Have put dentistry for myself and family high on my priority list
   b) Have put dentistry for myself and family low on my priority list
   c) Dentistry is on my list but it's hard to find

F. I think my present state of dental health is:
   a) Excellent
   b) Good
   c) Poor

G. I would rate my future dental health:
   a) Excellent
   b) Good
   c) Poor

H. Have you ever had a plan for your dentistry?
   a) Yes
   b) No

14. What are some questions about dentistry and oral health that you have never had adequately answered? _____

_____

_____

15. Do you desire to maintain your natural teeth and avoid dentures as long as possible? ❑ Yes ❑ No