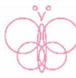

w h o l e   l i f e   d e n t i s t r y

YOUNG, BREEDLOVE & JUSTICE

Date: ________________________

Patient's Name: ______________________________________ Title: Mr. Mrs. Miss Dr. Ms.

Preferred Name:____

Street Address: ____

City: _______________________ State: ______________ Zip: ______________

Preferred Phone: ____________________________ Other Phone: _________________________

Email: ____

Date of Birth: _____________________________________ Age: _____________

Social Security No. _________________________________

Occupation: ____

Employer____

Employer Address: ____

Patient Referred By: ____

Person Financially Responsible for this account/Guarantor): _________________________________

Billing address (if different than above) ____

Dental Insurance Carrier ____________________________ Group #: _________________________

Subscriber's Name: ____

Subscriber's SSN: ______________________________ Subscriber's Date of Birth: _______________

Emergency Contact (Name and Phone Number): ____

I hereby give permission to use the above information for the purpose of establishing an account, obtaining credit, and transmitting information to and from insurance carriers and other parties. I agree to be responsible for payment of all balances on this account. Balances over 90 days are subject to interest compounded. I give my permission to Young, Breedlove, & Justice DDS, Inc. to utilize any photos or images generated of my mouth, teeth, or face for teaching and education purposes.

Signature: ____ Date: _____________________

(Continue to next page)

Why are you here today?____

Approximate date of last dental visit?____________________________________

What treatment was done at that visit?___________________________________

Are you happy with your smile? .... Yes No
Have you lost or broken fillings? .... Yes No
Do your gums feel tender or swollen? .... Yes No
Are your teeth noticeably sensitive to cold food/drinks? .... Yes No
Do you clench or grind your teeth? .... Yes No
Does your jaw ever feel tire or stiff? .... Yes No
Does your jaw click or pop? .... Yes No
Has your jaw ever locked open or closed? .... Yes No
Do you have frequent headaches or migraines? .... Yes No
Have you had trauma or injury to your face, jaw, or teeth? .... Yes No
Have you had orthodontic treatment? (i.e. braces, Invisalign).......... Yes No
Does having a dental appointment make you anxious? .... Yes No
Do you wear any partials or dentures?.......... Yes No
Do you wear any oral appliance? (i.e. night guard or sleep apnea appliance).......... Yes No
Have you ever received or considered cosmetic injections like Botox? .... Yes No
Would you like to discuss sedation dentistry? .... Yes No

Are there any additional dental concerns you would like to discuss today? If so, please write them below:

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