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(800) 243-4675

PATIENT NUMBER

N.P. # ______

NAME ______ Last ______ First ______ Initial ______ Date of Birth

IF CHILD:
PARENT'S NAME ______

ADDRESS ______

TELEPHONE: HOME ______ BUSINESS ______

DENTAL INSURANCE ______ MEDICAL ASSISTANCE ______

DATE OF LAST DENTAL VISIT ______ ARE X-RAYS AVAILABLE? Yes ☐ No. ☐

NAME OF FORMER DENTIST ______

ADDRESS ______

TELEPHONE ______

PAIN ☐ WHERE ☐ SWELLING ☐ WHERE ☐

TOOTHACHE ☐ WHERE ☐ OFF/ON ☐ CONSTANT ☐

LOST FILLING ☐ WHERE ☐ BROKEN TOOTH ☐ WHERE ☐

OTHER SYMPTOMS: ______

PREMEDICATION REQUIRED BECAUSE OF:

PROSTHETIC JOINTS ☐ HEART MURMUR ☐ RHEUMATIC FEVER ☐

MITRAL VALVE PROLAPSE ☐ OTHER ☐

**PURPOSE OF VISIT:**

RELIEF OF PAIN ☐ CONSULTATION ☐ SECOND OPINION ☐

EXAMINATION ☐ PROPHYLAXIS ☐ TREATMENT ☐

PATIENT WISHES TO SEE: DR. ______

**ATTITUDE:**

FRIGHTENED ☐ HOSTILE ☐ SHY ☐ VERY PLEASANT ☐ NEUTRAL ☐ OTHER ☐

REMARKS: ______

APPOINTMENT ON: ______

X-RAYS SENT OR CALLED FOR: YES ☐ NO ☐ DATE: ______

WHOM MAY WE THANK FOR THIS REFERRAL: ______

INFORMATION TAKEN BY: ______ DATE: ______

Form No. T320TI

# TELEPHONE INFORMATION

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