G. Robert Marye, DDS, PA
Smiles of Texas · A Family Practice
Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient Name: ________________________________ **Date of Birth:** _________ **Sex:** ___ **Age:**____

Home address: ____________________________ **City:** ________________**State:**_____ **Zip:**______

Home phone: __________________ **Cell:** ____________________ **Work:**_________________

E-mail address___________________________________ **Is this a good way to contact you? Y N**

Employer/ occupation: ____________________ **Driver's License# :**________________**State:**____

Social Security#:_____________________ **Spouse's name and Phone #:**______________________

Emergency contact (other than spouse):____

Physician's name and number: _______________________________ **Last Medical Exam:** ______

Previous Dentist: ____ **Last Dental Exam:** ________

Who may we thank for referring you? ____

Primary Dental Insurance: _____________________________________ **Group #:**______________

Subscriber's name: __________________________ **Date of Birth:** __________**ID#:**_____________

Secondary Dental Insurance: __________________________________ **Group #:**_______________

Subscriber's name: __________________________ **Date of Birth:**__________ **ID#:**_____________

Dental History (check if yes)

HAVE YOU:

- Ever been told you have gum problems______☐
- Ever been treated for Gum Disease_________ ☐
- Ever had orthodontic treatment _____________☐
- Had any shifting of any teeth ______________ ☐
- Had instructions on how to control plaque in your mouth ______________________ ☐
- Had immediate relatives lose all their natural teeth ________________________ ☐
- Ever had a bad dental experience___________☐
- Had dental x-rays in the last year __________ ☐
- Ever had prolonged bleeding after injury or tooth extraction ___________________ ☐
- Ever had any fear of dental treatment ____ ☐
- Ever had sore or popping jaw joints _______ ☐

Do You:

- Have Chronic bad breath ___________ ☐
- Have sore teeth ____________________☐
- Have gum abscesses ______________ ☐
- Have bleeding gums_______________☐
- Have tooth sensitivity _____________ ☐
  - to heat _______________☐
  - to cold _______________ ☐
  - to sweets ______________☐
  - to pressure _____________ ☐
- Awaken with a sore jaw ____________ ☐
- Have fever blisters frequently _______ ☐
- Have mouth ulcers frequently _______ ☐
- Bruise easily _____________________ ☐
- Clench your teeth day or night ______ ☐

MAIN REASON FOR TODAY'S VISIT____

____

Staff Initials: ________