Eric Wenzel D.D.S., P.S.

Fellow of the Academy of General Dentistry

Patient Biography

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Sex: ☐ M ☐ F Birthdate: _____ SS/HIC/Patient ID#: _____

Patient Employer/School: _____ Occupation: _____

Employer/School Phone: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone: _____

Insurance

Person Responsible for Account: _____ Relation to Patient _____

Address: _____ Phone: _____

Place of employment: _____

Insured's Birthdate: _____ ID#/Soc. Sec. #: _____ Group #: _____

Insurance Company: _____ Insurance Phone: _____

Dental History

Reason for Today's Visit: _____ Date of last dental care: _____

Former Dentist: _____ Date of last dental X-rays: _____

Check if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____