Welcome to Serene Dental

Dental history

Reason for leaving last dentist____

Reason for today's visit______________________________Date of last dental care?__________

How did you hear about our office?____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. You probably never thought of these issues. Please check what best expresses how you feel about the following questions:

Tell us in your opinion, what you think the present state of the health of your mouth is? ____________________

How do you feel about the appearance of your face and smile?______________________________

What do you already know about our office and what are your expectations?

____

What kind of a good dental experience would develop the trust for us to be your dentist?

____

Has the cost of dental treatment been concern for you, and how can we help there? ____________________

Chec ☑ if you have any of the following:

- Bad breathe
- Bleeding gums
- Sensitive teeth
- Broken fillings/food impaction
- Clenching/Grinding
- Jaw pain/popping/clicking
- loose teeth

How often do you brush and floss?____

Insurance Information

Primary

Name of Insured:______________________ID #________________DOB____________

Insured's Employer Name:________________________Group #____________________

Insurance Plan Name: ____

Patient's relationship to insured: Self Spouse Child Other

Secondary

Name of Insured:______________________ID#________________DOB____________

Inusred's Employer Name:________________________Group # ____________________

Insurance Plan Name: ____

Patient's relationship to insured: Self Spouse Child Other

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby consent my dentist to take any necessary X-rays, models, and photographs and perform a thorough diagnosis and treatment as needed. I also consent my dentist to perform all recommended treatment mutually agreed upon by us, and use of appropriate medication and therapy indicated for such treatment.

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Patient/Parent/Legal guardian signature **Date**