Richard W. Van Gurp, D.D.S.
704-542-2884

PATIENT INFORMATION

Patient's Full Name ____________________ Nickname ____________________
Address ____________________ Birthdate ____________________
City/State/Zip ____________________ Sex: Male Female
____________________ Home Phone: __________ Work: __________
Marital Status: Single Married Divorced Widowed Cell: __________ Email: __________
Physician's Name & Medical Group: ____________________
Address: ____________________
Address¨ ____________________ Phone Number: ____________________

CHILD/TEEN INFORMATION (To be filled out by parent)

Father's Name ____________________ Mother's Name ____________________
Birthdate __________ SS# __________ Birthdate __________ SS# __________
Employer ____________________ Employer ____________________
Position ____________________ Position ____________________
Home Phone __________ Work__________ Home Phone __________ Work__________
Driver's License #____________________ Driver's License #____________________
Patient's School __________Grade __________ Person present at exam Mother__ Father___ Other________

Because ____________________ is a minor, it is customary to have parental consent before any necessary dental service can be given by Dr. Van Gurp. Authorization is granted in writing.

____________________ / __________

Signature (Parent or Guardian) *Date*

ADULT INFORMATION

Birthdate __________ SS# __________ Spouse Name ____________________
Employer ____________________ Spouse Birthdate __________ SS# __________
Position ____________________ Employer ____________________
Home Phone __________ Work__________ Position ____________________
Driver's License # ____________________ Home Phone __________ Work__________
Driver's License # ____________________

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE:

Insurance Company Name: ____________________
Employee/Subscriber: ____________________
Policy/Group#: ____________________

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DENTAL QUESTIONNAIRE

PATIENT ______________________________ DATE ________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

MOUTH		
Bleeding, sore gums	YES	NO
Unpleasant taste/bad breath	YES	NO
Burning tongue/lips	YES	NO
Frequent blister, lips/mouth	YES	NO
Swelling/lumps in mouth	YES	NO
Ortho treatment (braces)	YES	NO
Biting cheeks/lips	YES	NO
Clicking/popping jaw	YES	NO
Difficulty opening or closing jaw	YES	NO

TEETH		
Loose teeth	YES	NO
Sensitive to hot	YES	NO
Sensitive to cold	YES	NO
Sensitive to sweets	YES	NO
Sensitive to biting	YES	NO
Food Impaction	YES	NO
Clenching/grinding	YES	NO
If so, when ____________________		
Shifting in bite	YES	NO
Change in bite	YES	NO

PLEASE CIRCLE ONE ANSWER FOR EACH CATEGORY

PRESENT DENTAL CONDITION

Do you now have any discomfort with your mouth?	none	some	a lot
I feel my teeth are:	very healthy	some disease/decay	in poor shape
I feel the appearance of my mouth is:	excellent	satisfactory	unsatisfactory
I would like to improve the health/appearance of my mouth:	very much	somewhat	not much

PAST DENTAL CARE:

Name of prior dentist ____________________ Date of last visit ______________

In the past I have gone to the dentist:	regularly	occasionally	emergencies only
I have followed my dentist's recommendations:	regularly	occasionally	rarely
The last dental treatment I received was for:	exam/cleaning	filling/other restoration	emergency care
I have had problems or pain with past dentistry:	no	yes/moderate	yes/serious
Dentistry for myself and my family is:	high priority	moderate priority	low priority

HOME CARE:

I brush my teeth:	twice (or more) per day	once per day	not regularly
I floss my teeth:	routinely (once per day)	occasionally	rarely or never

FEELINGS ABOUT DENTAL CARE:

The thought of dental care makes me:	not nervous	somewhat nervous	very nervous
My greatest fear about dental treatment is:	discomfort/pain	expense	time it takes
The kind of dental care I want now is:	for highest level of dental health	adequate maintenance	emergency only

1. What are some questions about dental care that have not been answered for you? ______________________________
____
2. What did you dislike about your past dental care/dental office? ______________________________
____
3. What things have you appreciated about your past dental care/dental office? ______________________________
____
4. If you could change anything about your teeth, what would you change? ______________________________
____