Dental Clinic Patient Record Form

Personal Information

Full Name

Date of Birth

Gender

--Select--

Phone Number

Address

Email Address

Medical History

Have you had, or do you currently have, any of the following?

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ Allergies ☐ Other

Current Medications

Medication Allergies

Dental History & Concerns

Primary Dental Concern

Describe your main dental issue or reason for visit

Have you experienced any of the following?

☐ Tooth Pain ☐ Bleeding Gums ☐ Sensitivity ☐ Bad Breath ☐ Jaw Pain

Date of Last Dental Visit

Insurance Information (if applicable)

Insurance Provider

Policy Number

Emergency Contact

Name

Phone Number

Relationship

Submit