Welcome to Leinassar Dental Excellence

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

Today's Date _____

About You

Patient's Name_____, Preferred Name_____

Date of Birth ____/____/_____ Social Security Number _____-_____-_____

Responsible Party _____

Mailing Address _____ City_____ State_____ Zip _____

Home Address _____ City_____ State_____ Zip _____

Home Phone _____Cell Phone_____ Work Phone_____

Patient's Employer _____ Phone _____ Occupation _____ How Long? _____

Email _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Spouse's Name _____ DOB____/____/_____

Spouse's Employer _____ Phone/Cell _____ Occupation _____ How Long? _____

Whom can we thank for telling you about us? _____

Name of emergency contact person _____ Phone _____

Dental Insurance Information

Insured's Name _____ SSN _____-_____-_____ DOB ____/____/_____

Insurance Company _____ Employer _____

Group No. _____ ID No. _____ Local No. _____

Insurance Company Address _____ City _____ State _____ Zip _____

Dental Information

Why have you come to the dentist today? _____

Many patients consult Dr. Leinassar for a second opinion. Have you seen another dentist for your dental needs? ☒ Yes ☒ No

If yes, please explain _____

The date of your last dental visit: _____ Previous dentist's name: _____

How would you describe the condition of your teeth and gums? ❑ Good ❑ Fair ❑ Poor

Are you currently in pain or discomfort with your teeth or gums? ❑ Yes ❑ No

If yes, please explain _____

If you could wave a magic wand and change anything you could about the appearance of your smile, what would you like to do? _____

_____

If you could easily and safely whiten your teeth, would you be interested? ❑ Yes ❑ No

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? ❑ Yes ❑ No

Have you ever experienced pain in your jaw joint? ❑ Yes ❑ No Do you grind/clench your teeth? ❑ Yes ❑ No

Have you ever been treated for TMJ symptoms? ❑ Yes ❑ No If yes, please explain _____

_____