Midway Dental Center

Dr. James L. Strawn, D.D.S.

PATIENT INFORMATION:

Name ______________________ Date of Birth ______________ Date ______________

Address ______________________ City ______________ State ________ Zip ________

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor S. S. # ______________

☐ Separated ☐ Divorced ☐ Partnered for ______ years Driver's Lic. # ______________

E-mail ______________________ Home Phone (______) ______________ Cell Phone (______) ______________

Employer/School ______________________ Employer/School Phone (______) ______________

Spouse or Parent's Name ______________ Employer ______________ Work Phone (______) ______________

Whom may we thank for referring you? ______________________

Person to contact in case of emergency ______________________ Phone (______) ______________

RESPONSIBLE PARTY:

Name of Person
Responsible for this Amount ______________________ Relation to Patient ______________

Address ______________________ Home Phone (______) ______________

Date of Birth ______________________ Work Phone (______) ______________

Currently a patient in our office? ☐ Yes ☐ No E-mail ______________________ Cell Phone (______) ______________

INSURANCE INFORMATION:

Name of Insured ______________________ Relationship to Patient ______________

Date of Birth ______________ Social Security # ______________________

Employer ______________________ Work Phone (______) ______________

Insurance Company ______________________ Group # ______________ Ins. Phone (______) ______________

Address ______________________ City ______________ State ________ Zip ________

DENTAL HISTORY:

Reason for today's visit ______________________ Date of last dental care ______________

Former Dentist ______________________ Date of last dental X-rays ______________

Former Dentist's Phone # ______________________

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

☐ Bad Breath ☐ Grinding teeth ☐ Sores or growths in your mouth

☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Dental Implants:

☐ Clicking, popping jaw or headaches ☐ Periodontal treatment What area ______________

☐ Food collection between the teeth ☐ Sensitivity to cold, hot, sweets or biting

How do you feel about the appearance of your teeth? ______________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment ______________________

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What would you like us to do today? ______________________

Are you in dental discomfort today? ______________________