Patient Personal Information Form

Today's Date ____________

(For Internal Office Use Only)

Patient Name: First ____________ MI ____ Last ____________ **Date of Birth** ____________

Spouse/Significant Other's Name ____________ **Patient in the Practice** ☐ Yes ☐ No

Children's Name ____________ **Age** ____ **Patient in the Practice** ☐ Yes ☐ No

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Children's Name ____________ **Age** ____ **Patient in the Practice** ☐ Yes ☐ No

Hometown ____________ **College** ____________

Occupation ____________ **Job Title** ____________

Pets ____________ **Favorite Restaurants** ____________

Hobbies ____________

Sporting Interests ____________

Favorite or Recent Vacations ____________

Community Involvement ____________

Philanthropic Causes ____________

Milestones with dates *(weddings, anniversaries, reunions, promotions, etc.)* ____________

Other personal information ____________

List names of patients this patient has referred to our practice

____________ ____________ ____________ ____________

Dental Patient History

Attitude toward dentistry ____________

Has patient shown resistance or declined treatment plans? ☐ Yes ☐ No

(if yes, explain situation) ____________

Is patient fearful of dentistry or had anxiety with treatment ☐ Yes ☐ No

(if yes, explain) ____________

Has patient complained about result following treatment or expressed concern with any treatment in our practice? ☐ Yes ☐ No

(if yes, explain) ____________

Are there any other patient-related issues or concerns for provider to be made aware ☐ Yes ☐ No

(if yes, explain) ____________

Has patient cancelled or failed to arrive at multiple appointments with our practice? ☐ Yes ☐ No

(if yes, explain situation and whether it has been resolved) ____________

Has patient been late for multiple appointments? *(if yes, explain situation and whether it has been resolved)*

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