CENTRAL TEXAS DENTAL CARE
506 North Hewitt Drive-Hewitt 76643
254.666.1686/Fax: 254.666.9252

PATIENT INFORMATION:

Patient's Full Name: _____Date:_____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Date of Birth: _____Social Security Number: _____

Driver's License Number: _____ Email: _____

Whom may we thank for referring you? _____

Name & Address of person responsible for this account: _____

_____Social Security Number: _____

Other immediate family members treated in this office:_____

DENTAL INSURANCE INFORMATION:

Subscriber's Name: _____

Date of Birth: _____Social Security Number: _____

Employer Name: _____ Insurance Co. _____

ID Number: _____ Group Number: _____

DENTAL HISTORY:

The following information is needed for treatment to protect your general health and will be held in the strictest confidence.

1. Does dental treatment make you nervous? _____

2. Would you prefer to be sedated should you need dental work? _____

3. Is there anything that you would like to change about any of your teeth or your dental smile?
_____

4. Would you like to have whiter teeth? _____

5. Do you have any jaw joint problems?
   - ☐ Clicking or popping when opening or closing
   - ☐ Difficulty opening or closing jaw
   - ☐ Clenching or grinding
   - ☐ Excessive tooth wear
   - ☐ Pain in the jaw joint
   - ☐ Headaches
   - ☐ Ringing in the ears

6. Do you wear any type of Sleep appliance/C-Pap, TMJ appliance, or any other type of appliance?
_____