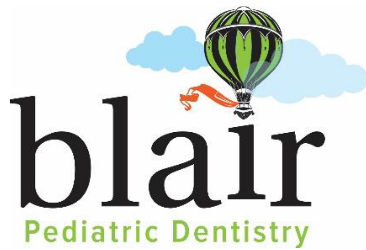

RANDALL BLAIR D.M.D.

NEW PATIENT INFORMATION

LAST________________________FIRST________________________________ MI_________
PREFERRED NAME:____ SEX: M F
BIRTH DATE: ______/_______/_________

HEAD OF HOUSEHOLD

LAST_________________________FIRST________________________________MI_________ SEX: M F
BIRTH DATE: ___/____/_____ SS#______-______-________ MARITAL STATUS: S M W D
ADDRESS____CITY_________________________
STATE ________ZIP ________WORK________________________CELL _____________________________
EMPLOYER____NUMBER OF YEARS________
EMAIL:____
RELATIONSHIP TO PATIENT____

SPOUSE/OTHER PARENT INFORMATION:
LAST________________________ FIRST______________________EMPLOYER ___________________
SS# __________-__________-____________
BIRTH DATE _________/______/_________
CELL PHONE ____________________________________ SEX: M F
ADDRESS____CITY___________________
STATE ______________ ZIP __________
EMAIL:___________________________________ RELATIONSHIP TO PATIENT________________________

REFERRAL

How did you hear about our office?____
If patient, who?____
Does the patient have any siblings that go here already? CIRCLE: YES NO

DENTAL HISTORY

NAME OF PREVIOUS DENTIST________________________________PHONE____________________
HOW LONG HAS IT BEEN SINCE YOUR CHILD HAS SEEN A DENTIST? ________________________
DATE OF LAST X-RAYS___________________________________
HAS YOUR CHILD HAD ANY PERIODONTAL (GUM) PROBLEMS? ☐YES ☐NO
DO THEIR GUMS BLEED OR FEEL IRRITATED OR TENDER? ☐ YES ☐NO
DO THEY FLOSS REGULARLY? ☐ YES ☐NO
ARE THEIR TEETH SENSITIVE TO: ☐HOT ☐COLD ☐PRESSURE ☐SWEETS
DO THEY HAVE HEADACHES, EARACHES, OR NECK PAIN? ☐ YES ☐ NO
HAVE THEY WORN BRACES ON THEIR TEETH? ☐ YES ☐NO