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BOISE PROSTHODONTICS

NEW PATIENT INFORMATION

First Name: **Middle Name:** **Last Name:**

Preferred Name: **Title:** **Date:**

Birth Date: **S.S.#:** **Sex:**

Street Address: **City:** **State:**

Zip Code: **Home Phone:** **Cell Phone:**

Employer: **Work Phone:**

Emergency Contact: **Emergency Contact Phone:**

Referral Name:

DENTAL HISTORY

Last time you saw a dentist:?

What dental treatment was done at that time?

What are your dental concerns at this time?

What would you like dentistry to do for you?

If currently have dentures, how many sets have you had?

What do you like about your dentures?

What do you dis-like about your dentures?

Date: Signature:

Print Form