



Michael Sanders, D.M.D.
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Caring & Professional
Family Dentistry

How did you hear about our office? _____

Patient Information

Patient Name _____
Age _____ Date of Birth _____ SS # _____
Address _____
Home phone _____ Office Phone _____ Cell phone _____
Which number would you like us to use for contact? _____
Occupation _____
Employer _____
Name of Dental Insurance Plan _____
Group Number _____
Spouse's Name _____
DOB _____ SS# _____ Work Phone _____
Occupation _____
Employer _____
Person responsible for payment _____
Relationship to Patient _____

Dental History

Is there anything bothering you today? Yes No
If yes, explain _____
What is the reason for today's visit? _____
Name of previous Dentist _____
When was your last dental visit? _____
Were X-rays taken of all your teeth at that time? Yes No
How often do you get your teeth cleaned? 3-4 months Every 6 months Yearly Other
Does food generally wedge between your teeth? Yes No
Are your teeth sensitive to heat, cold or sweets? Yes No
Do you grind or clench your teeth? Yes No
Do you experience popping or clicking in your jaw joints? Yes No
Are you troubled by bad breath or taste? Yes No
Do your gums bleed easily? Yes No
Have you ever been diagnosed with periodontal or gum disease? Yes No
Are there any growths or sore spots in your mouth? Yes No
Are you self-conscious about the appearance of your teeth? Yes No
Have you ever had an unpleasant experience in the dental office? Yes No
Are you satisfied with your past dentistry? Yes No
Does the thought of going to the dental office make you anxious? Yes No

"I have provided as accurate and complete a medical and personal history as possible including medications that I am currently taking as well as those to which I am allergic. I hereby consent to the use of anesthetics, X-rays and treatment as deemed necessary by the doctor. I understand that I can ask Dr. Sanders or any of his staff any questions that arise prior, during or after treatment."

Signature _____