MAIN STREET DENTAL
Dr. Erin Cox

Patient Name_____

Other family members in practice (please list names and ages)

_____

_____

Whom may thank for referring you _____

When was your last visit _____

Previous Dentist (name, location and phone number) _____

_____

How often did you have your teeth cleaned / visits per year _____

	yes	no
Have you ever visited a Periodontist (Gum Specialist) for your cleanings		
Have you ever been told that you clench or grind		
Is your drinking water from a well		
Is your drinking water Fluoridated		
Does dental treatment make you nervous		

Any other information that you feel would be helpful to know _____

_____

Patient Signature _____

Date _____