DR. LLOYD KITCHIN □ 40 Main Street □ Succasunna □ NJ □ 973-584-2533

DENTAL HISTORY INFORMATION

Reason for today's visit : □ Exam/Cleaning □ Emergency □ Consultation Are you in any pain? □ Yes □ No How Long? _____

Former Dentist_____ Phone#: _____City/State_____

Date of last dental exam (Appx) _____Date of last dental x-ray_____How often do you brush _____x/day How often do you floss:_____

Do you have any of the following:

□ Bad Breath	□ Cigarette, cigar or pipe smoking	□ Gums swollen/tender	□ Pain around ear
□ Bleeding Gums		□ Jaw Pain	□ Periodontal TX
□ Blisters on lips/mouth	□ Clicking or popping in jaw	□ Lip or cheek biting	□ Sensitive to cold
□ Broken Fillings	□ Dry Mouth	□ Loose Teeth	□ Sensitive to hot
□ Burning sensation on tongue	□ Fingernail biting	□ Mouth Breather	□ Sensitive to sweets
	□ Food collecting b/w teeth	□ Mouth Pain	□ Sensitive to biting
□ Chew on 1 side of mouth	□ Grinding teeth	□ Orthodontic TX	□ Sores in mouth

Do you have more than one headache per month? □ Yes □ No Does your jaw ever pop or crack? □ Yes □ No

Does your jaw or facial muscles get tired or sore after chewing, sleeping, while under stress etc.? □ Yes □ No

Are you fearful of going to the dentist? □ Yes □ No Have you ever had an unpleasant experience at a dental visit? □ Yes □ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature of patient, parent or guardian _____ Date _____

INSURANCE INFORMATION

Primary Dental Insurance: _____

Address: _____Phone #: _____
City State Zip

Subscriber ID: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber's Employer: _____

Employer's Address: _____

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Secondary Dental Insurance: _____

Address: _____Phone #: _____
City State Zip

Subscriber ID: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber's Employer: _____

Employer's Address: _____

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____