R.Thomas Bayley III, DMD, P.C
1129 West Chester Pike
West Chester, PA 19382

Patient Information

Name ____DOB ____________ Mr Miss Mrs Ms Dr
(Last) (First) (Middle)

Marital Status: Single Married Divorced Widowed Driver's License # _________________

I prefer to be called __________________ I was referred to this office by ______________________

Address ____
____

Home Phone ______________ Cell Phone _______________ Work Phone _____________

E-mail Address _______________________________ Employer __________________SS# _____________

Spouse or Legal Guardian Information

Name ____ DOB ____________
(Last) (First) (Middle)

Address ____
____

Home Phone ______________ Cell Phone _______________ Work Phone ______________

Employer _______________________ SS# _____________________

Emergency Contact Name ______________________________ Phone# ______________________________

Dental Health History

What is important to you in a dentist or dental practice?____
Date of last x-rays and exam?_____________Date of last cleaning_________________________________
Have you had problems with prior dental treatment?____
Are you experiencing any discomfort now?____
Have you ever been pre-medicated prior to dental treatment? Yes □ No□
If yes, why?____
Have you been anxious about having dental treatment? Yes□ No□
What concerns do you currently have with your oral health or smile? (check all that apply)
□ jaw joint pain □ unhappy with appearance of teeth □tooth sensitivity to hot/cold or biting
□ clenching or grinding of teeth □ overbite □ food gets caught in between teeth
□ discolored teeth □ underbite □ difficulty chewing
□ crowding/crooked teeth □ uncomfortable bite □ bad breath
□ missing teeth □ old fillings □other________________________
□ spaces in between teeth □ old crowns ______________________________
□ loose tooth/teeth □ speech problems
□ tooth shape or size □ too much gum tissue when I smile
Have you ever had orthodontic treatment? □ Yes □ No
If yes, when?_____________________________________
Have you ever had periodontal treatment (deep cleanings, root planning, or periodontal surgery)? □ Yes □ No
If yes, when?____
Have you ever whitened your teeth in the past? □ Yes □ No
Are you interested in learning more about the following? (check all that apply)
□ teeth whitening □ tooth colored fillings □ at home oral hygiene care
□ clear aligners (Invisalign) □ dental implants □ replacing mercury fillings
□ veneers/porcelain crowns □ how to prevent periodontal disease □ tooth replacement options

Signature ____ Date ______________________________