Cambridge Practice Consultants
mydentalconsultant.com
Dunedin, FL • 800-595-2380

EMERGENCY CALL-IN FORM

DATE CALLED ________________APPT. DATE ____________

PATIENT NAME _____________________ADULT ___________CHILD/AGE ______

HOME PHONE ______________________WORK PHONE & EXT. _______________

WHEN WAS THE LAST TIME YOU SAW Dr. [name]? ___________________

IF NEVER, WHEN WAS THE LAST TIME YOU SAW A DENTIST?______________

HOW DID YOU HEAR ABOUT OUR OFFICE?________________________________

WHAT TYPE OF PAIN ARE YOU EXPERIENCING? ________________________

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WHICH TOOTH? UR LR UL LL

HOW LONG HAS IT BEEN HURTING? ____________ANY SWELLING? ______

MEDICATION?___________IS THE TOOTH BROKEN? ________________________

LOST FILLING? _____________________CHIPPED ____________________________

IS THE TOOTH SENSITIVE TO HOT OR COLD?____________IS IT LOOSE?______

IF NEW PATIENT, DO YOU HAVE A CURRENT SET OF X-RAYS AVAILABLE
FOR TRANSFER HERE? ____