PATIENT INFORMATION

Patient Name: ______________________ (Mr. Mrs. Miss) Nickname ____________
Last First Middle

Mailing Address: ______________________
Street City State Zip

Street Address: ______________________
(if different from above) Street City State Zip

Birthday: ___/___/___ Social Security # ___-___-___ Emergency Contact ________ Phone ________

Home Phone: ___-___-___ Work Phone ___-___-___ Ext. ________

Employer / School ____________ Position / Grade ____________

Employer Address ______________________

Spouse's Name ______________________
Last First Middle

Birthday: ___/___/___ Social Security # ___-___-___ Work Phone ____________

Employer / School ____________ Position / Grade ____________

Employer Address ______________________

Have you or a member of your family been a patient in our office before? Y N If yes, whom? ____________

Whom may we thank for referring you to our office? ______________________

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PRIMARY INSURANCE ______________________

Group Number Policy Number

Street Address City State Zip

Policy Holder's Name Date of Birth

___-___-___

Social Security # Relationship

Employer ______________________

SECONDARY INSURANCE ______________________

Group Number Policy Number

Street Address City State Zip

Policy Holder's Name Date of Birth

___-___-___

Social Security # Relationship

Employer ______________________

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PERSON RESPONSIBLE FOR PAYMENT: ______________________
(Responsible party must be over 18 years of age) Last First Middle

Mailing Address: ______________________
Street City State Zip

Street Address: ______________________
(if different from above) Street City State Zip

Birthday: ___/___/___ Social Security # ___-___-___ Drivers License # ____________

Home Phone: ___-___-___ Work Phone ___-___-___ Ext. ________

Employer: ______________________ Position ____________

Do your gums bleed when you brush? Yes ____ No ____

Are your teeth sensitive to heat or cold? Yes ____ No ____ Pressure Yes ____ No ____ Sweets Yes ____ No ____

Do you grind or clench your teeth? Yes ____ No ____

Do you have any fear of dental work? Yes ____ No ____

Date of last dental examination ____________ What was done at that time? ____________

How would you describe your current dental problem? ______________________

How do you feel about the appearance of your teeth? ______________________

Please complete back page