We are pleased you have selected us to provide dental care for you and your family.

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

Patient Information

Date ________ Patient's Name ____________________
Last First Middle

Address ____________________
Street Unit# City State Zip

Home Ph. # (____) ________ Work Ph. # (____) ________ Cell Ph. # (____) ________ Marital Status ________

Soc. Sec. # ______ - ______ - ______ Drivers Lic. # ________ E-Mail: ________

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name ________

Name of nearest relative not living with you ________ Relationship ________

If patient is a full-time student, fill in school name ________

School Address ________ Ph. # (____) ________

Emergency Contact ________ Ph. # (____) ________

Responsible Party Information

Name ____________________
Last First Middle

Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Relationship to Patient ________

Residence ____________________
Street Apt# City State Zip

Mailing Address ____________________
Street City State Zip

How long at this address ________ Home Ph.# (____) ________ Work Ph.# (____) ________ Fax# (____) ________

Previous Address (if less than 3 years) ________

Employer ________ Occupation ________ No. Years Employed ________

Employer Address ________

Spouse's Name ________

Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Work Ph.# (____) ________ Fax# (____) ________

Employer ________ Occupation ________ No. Years Employed ________

Employer Address ________

Insurance Information

Insured's Name ________ Insured's SS# ________ Insured's DOB ________ ID# ________

Insurance Company ________ Group # ________

Insurance Co. Address ________ Ph. # (____) ________

Insured's Employer ________ Ph. # (____) ________

Do you have dual coverage? Yes __ No __ If yes: **Please complete the following secondary insurance information.**

Insured's Name ________ Insured's SS# ________ Insured's DOB ________ ID# ________

Insurance Company ________ Group # ________

Insurance Co. Address ________ Ph. # (____) ________

Insured's Employer ________ Ph. # (____) ________

Dental Information

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 visit ________ What was done at the time? ________

Former Dentist Name ________ City ________

How would you describe your current dental problem? ________

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