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PATIENT INFORMATION

Today's Date _____
Patient's Name (Mr. Mrs. Ms.) _____ SS# _____ Birthdate _____
Residence Address _____ Mailing _____
City _____ State _____ Zip _____ Home Phone (____)_____
E.mail address:_____ Cell Phone:_____
Occupation _____ Employer _____ Business Phone/Ext. (____)_____
Business Address _____ City _____ State _____ Zip _____
Please Circle One: Minor Single Married Separated Divorced Widowed

Name of Spouse _____ SS# _____ Birthdate _____
Occupation _____ Employer _____ Business Phone/Ext. (____)_____
Business Address _____ City _____ State _____ Zip _____
Responsible Party if Patient is a Minor _____ Relationship to Minor _____
Address (Home/Business) _____ Phone (Home/Business) (____)_____
Name, Address and Phone of relative NOT living with you: _____
_____

INSURANCE INFORMATION

Insured's Name _____ Insured's SS# _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Phone # (____) _____
_____
Is policy connected with your union? If yes: Name of Union _____ Local No. _____

Do you have dual coverage? If yes: **Please complete the following secondary insurance information**
Insured's Name _____ Insured's SS# _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Phone # (____) _____
_____
Insured's Employer _____ Phone # (____) _____

DENTAL HISTORY

Referred By _____ Your Dentist _____ How Long? _____
Your Previous Dentist _____ City _____ How Long? _____
When was your last cleaning by a Hygienist? _____ Cleanings per year? _____
How often do you brush? _____ Floss? _____ See your Dentist? _____

DO YOU OR HAVE YOU EVER HAD: (Circle)

1. Head or neck injuries Yes/No
2. Sore or sensitive teeth Yes/No
3. Bleeding gums Yes/No
4. Grind or clinch teeth Yes/No
5. Difficulty Chewing Yes/No
6. Anxiety of dental treatment Yes/No
7. Reaction to "Novocaine" Yes/No
8. Orthodontic treatment Yes/No
9. Periodontal Disease (Pyorrhea) Yes/No
10. Trouble Opening/Closing your jaw Yes/No
11. Sores on lips/mouth that are slow to heal Yes/No
12. Bleeding or slow healing after an extraction Yes/No
13. Dissatisfaction w/appearance of your teeth Yes/No
14. When was your last dental x-ray taken? _____