



**WE WOULD LIKE TO GET TO KNOW YOU BETTER!**  
DATE \_\_\_\_\_

CHART # \_\_\_\_\_

**PATIENT**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Apt. # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone Number...  
 House: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Social Security: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: (M) (F) Email Address \_\_\_\_\_  
 I.D/Drivers License #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Emergency Contact: Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_

**RESPONSIBLE PARTY (if applicable)**

**INSURANCE INFO**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Name of Insurance Co: \_\_\_\_\_ Phone # \_\_\_\_\_

**PERSONAL REFERENCES**

1. Name: \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_
2. Name: \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

**How do you intend to pay for today's visit? Insurance Medi-cal Cash/Credit Other**

**We would like to take care of your needs first...**

Any present dental problems? \_\_\_\_\_  
 Are you satisfied with your teeth and their appearance? Yes No  
 Does dental treatment make you nervous? Yes No  
 I think my dental health is..... [ ] excellent [ ] good [ ] fair [ ] poor  
 If I could, I would make my teeth... [ ] whiter [ ] straighter [ ] healthier  
 [ ] other Please Explain: \_\_\_\_\_

I hereby certify that the information above is accurate. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this dental professional from my insurance co.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date