

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

Patient Information

Date _____ Patients Name _____
Last First Middle
(If patient is a full time student fill in school name) _____
Address _____
Street City State Zip
Home Phone _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____
Name of nearest relative not living with you _____
Complete Address _____ Phone _____

Responsible Party Information

Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____
Street City State Zip
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Ph. # _____
Is policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____
Do you have dual coverage? Yes _____ No _____ If yes: **Please complete the following secondary insurance information.**
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Co. _____ Group No. _____ Local No. _____
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 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