Welcome

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

Patient Information

Patient's Name _____
Last First Middle

Address _____

Home Phone # (____)_____ Work Phone # (____)_____ Cell Phone # (____)_____

Social Security #_____ Drivers License #_____ E-Mail_____

Birth Date____/____/____ Age_____ Sex ☐ Male ☐ Female

Parent / Guardian if patient is a minor_____ Relationship to Patient_____

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

School Address_____ Phone# (____)_____

Emergency Contact_____ Phone# (____)_____

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

Responsible Party Information

Name_____ Relationship to Patient_____
Last First Middle

Address_____

Home Phone # (____)_____ Cell Phone # (____)_____ Fax # (____)_____

Social Security #_____ Birth Date____/____/____ E-Mail_____

Employer_____ Occupation_____ No. Years Employed_____

Employer Address_____ Work Phone # (____)_____

Insurance Company_____ Phone # (____)_____

Insurance Company Address_____ Group #_____

Spouses Name_____ Relationship to Patient_____

Social Security #_____ Birth Date____/____/____ Cell Phone # (____)_____

Employer_____ Occupation_____ Work Phone # (____)_____

Insurance Company_____ Phone # (____)_____

Insurance Company Address_____ Group #_____

Dental Information

What is your main interest in your visit to our office?_____

Are you having pain or discomfort at this time?_____ If yes, please specify_____

Former Dentist_____ City_____

Date of last dental visit_____ Date of last x-rays_____

Have you had problems with any of the following?

☐ Bleeding Gums ☐ Periodontal Disease ☐ Sensitivity to Pressure

☐ Grinding or Clenching Teeth ☐ Sensitivity to Temperature ☐ Sensitivity to Sweets

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

Have you ever experienced an adverse reaction during or in conjunction with a dental appointment?_____

Do you have any fear of dental work?_____