

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 _____
Last First Middle Relationship to Patient _____

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? _____