

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

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

Patient Information

Date _____	Patient's Name _____	_____	_____	_____	_____	_____	_____
Address _____	Street _____	Unit# _____	City _____	State _____	Zip _____	_____	_____
Home Ph. # () _____	Work Ph. # () _____	Cell Ph. # () _____	_____	_____	_____	_____	_____
Soc. Sec. # _____ - _____ - _____	Drivers Lic. # _____	E-Mail: _____	_____	_____	_____	_____	_____
Birthdate ____ / ____ / ____	Sex M F	If patient is a minor, give parent's/guardian's name _____					
Name of nearest relative not living with you _____				Relationship _____			
If patient is a full-time student, fill in school name _____							
School Address _____				Ph. # () _____			
Emergency Contact _____				Ph. # () _____			

Responsible Party Information

Name _____	_____	_____	_____	_____	_____	_____	_____
Soc. Sec. # _____ - _____ - _____	Birthdate ____ / ____ / ____	Relationship to Patient _____				_____	_____
Residence _____	Street _____	Apt# _____	City _____	State _____	Zip _____	_____	_____
Mailing Address _____	Street _____	City _____	State _____	Zip _____	_____	_____	_____
How long at this address _____	Home Ph.# () _____	Work Ph.# () _____	Fax# () _____	_____	_____	_____	_____
Previous Address (if less than 3 years) _____							
Employer _____	Occupation _____	No. Years Employed _____				_____	_____
Employer Address _____							
Spouse's Name _____				Relationship to Patient _____			
Soc. Sec. # _____ - _____ - _____	Birthdate ____ / ____ / ____	Work Ph.# _____	_____	_____	_____	_____	_____
Employer _____	Occupation _____	No. Years Employed _____				_____	_____
Employer Address _____							

Insurance Information

Insured's Name _____	Insured's Soc. Sec # _____	Insured's DOB _____	_____	_____
Insurance Company _____	Group # _____	_____	_____	_____
Insurance Co. Address _____	Ph. # () _____	_____	_____	_____
Is policy connected with your union? Yes ___ No ___	Name of Union _____	Local # _____	_____	_____
Do you have dual coverage? Yes ___ No ___ If yes: Please complete the following secondary insurance information.				
Insured's Name _____	Insured's Soc. Sec. # _____	_____	_____	_____
Insurance Company _____	Group # _____	Local # _____	_____	_____
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 visit _____	What was done at the time? _____	_____	_____	_____
Former Dentist Name _____	City _____	_____	_____	_____
How would you describe your current dental problem? _____				
How do you feel about the appearance of your teeth? _____				