PATIENT INFORMATION

Patient Name: _____ Email address: _____ Date: _____
Last First M

Address: _____
Street Apt. # City State Zip

Birthdate: ___/___/___ Telephone: Home: _____ Work: _____ Cellular/Pager: _____

Height: _____ Weight: _____ Sex: ☐ M ☐ F Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated

If Student, _____ ☐ Full Time ☐ Part Time
Name of School/College City State Grade

Patient's Employer: _____ Occupation: _____ SS#: _____

Business Address: _____
Street Suite # City State Zip

Spouse Name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

Who reffered you to us? Or how did you hear about us? _____

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address (if different from above): _____
Street Apt. # City State Zip

Birthdate: ___/___/___ Telephone: Home: _____ Work: _____

SS #: _____ Driver's License #: _____

Primary Dental Coverage Information **If you do NOT have primary coverage, please check this box: ☐**

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

Secondary Dental Coverage Information **If you do NOT have secondary coverage, please check this box: ☐**

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

DENTAL HISTORY

Please answer each question by circling Yes or No.

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Describe: _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Have your past experiences in a dental office been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-ray series: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

DO NOT WRITE IN THIS SPACE

DATE: _____ **REVIEWED BY:** _____ **DENTIST'S COMMENTS:** _____