PATIENT INFORMATION

Patient Name: ______ (Last) ______ (First) ______ (M) Email address: ______ Date: ______

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, ______ (Name of School/College) ______ (City) ______ (State) ______ (Grade) ☐ Full Time ☐ Part Time

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:** ______