DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ I PREFER TO BE CALLED _____

MARITAL STATUS: _____ NAME OF SPOUSE: _____

IF A CHILD, PARENTS OR GUARDIANS NAME: _____

HOME ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

D.O.B.: _____ S.S. NO.: _____ DRIVER'S LICENSE: _____

MAILING ADDRESS (If different from above): _____

EMPLOYMENT INFORMATION

PATIENT OR PARENT EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____

WORK PHONE: _____ MAY WE CALL YOU AT WORK? _____

SPOUSE EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____

WORK PHONE: _____ MAY WE CALL THEM AT WORK? _____

DENTAL INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY: _____ GROUP NUMBER: _____

INSURANCE COMPANY ADDRESS: _____ TELEPHONE: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER SOCIAL SECURITY #: _____

NAME OF SECONDARY INSURANCE COMPANY _____ GROUP NUMBER: _____

INSURANCE COMPANY ADDRESS: _____ TELEPHONE: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER SOCIAL SECURITY #: _____

PLEASE BRING FORMS, BOOKLETS, ETC. THIS WILL ENABLE OUR OFFICE TO BETTER HELP YOU WITH YOUR BENEFITS.

GENERAL INFORMATION

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____ TELEPHONE #: _____

WERE YOU REFERRED TO US BY ONE OF OUR PATIENTS? _____ IF YES, WHOM MAY WE THANK? _____

IF NO, HOW DID YOU FIND US? _____

OTHER FAMILY MEMBERS SEEN BY US? _____

WHAT ASPECTS OF DENTISTRY INTEREST YOU MOST? _____

I ATTEST TO THE BEST OF MY KNOWLEDGE THE INFORMATION PROVIDED ABOVE IS ACCURATE AND COMPLETE. ANY CHANGES IN HEALTH STATUS OR MEDICATIONS WILL BE REPORTED TO THE DOCTOR AT THE NEXT VISIT.

PLEASE CIRCLE METHOD OF PAYMENT: CASH, CHECK, MASTER CARD, VISA OR DISCOVER CARD

PAYMENT POLICY: PAYMENT IS REQUESTED AT THE TIMES SERVICES ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE. ASSIGNMENT ACCEPTED FROM INSURANCE COMPANIES WILL BE ACCEPTED WITH THE UNDERSTANDING THAT THE PATIENT PAY THEIR PORTION AS THE WORK IS PREFORMED UNLESS OTHER ARRANGEMENTS ARE MADE.

I/WE UNDERSTAND AND AGREE THAT ANY CREDIT GRANTED SHALL BE PAID PROMPTLY IN ACCORDANCE WITH TERMS AND AGREEMENTS AND IN THE EVENT OF DEFAULT TO PAY REASONABLE COLLECTION CHARGES AND/OR ATTORNEY FEES.

_____ _____

SIGNATURE OF PATIENT SIGNATURE OF GUARDIAN

DENTAL HISTORY

Please check any of the items below that you currently have or have had.

_____ orthodontic treatment (braces) - etc
_____ periodontal treatment (gum surgery)
_____ bleeding or sore gums
_____ unpleasant taste/ bad breath
_____ frequent blisters on lips/ mouth/ mouth ulcers
_____ swelling/ lumps mouth/ neck
_____ sensitivity to hot, cold, sweets or pressure
_____ TMJ (jaw) problems
_____ food impactions (food packs between teeth)
_____ clenching/ grinding
_____ dry mouth
_____ mouth breathing/ snores at night
_____ retainer, nightguard, Removable partial denture

Are you having any discomfort at this time? _____

Do you have any apprehensions or fear of dentistry? If yes, please explain. _____

_____

Name of last dentist: _____

Date and reason for your last dental visit: _____

Last dental X-rays taken: Last Cleaning: _____

Do you use a _____ soft _____ medium _____ hard brush? How many times a day? _____ How often do you floss? _____

Do you use fluoride supplements? _____ Brand of toothpaste used _____