Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name ______________________________ Soc. Sec. # ______________
Last Name *First Name* *Initial*

Address ______________________________

City ______________ State ______ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________

Sex ❑ M ❑ F Age ________ Birthdate ______________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone ______________

Business Email ______________________________

Whom may we thank for referring you? ______________________________

Notify in case of emergency ______________ Home Phone ______________

Cell Phone ______________ Business Phone ______________

Dental History

What would you like us to do today? ______________ Are you in dental discomfort today? ______________

Former Dentist ______________ Address ______________

Dentist's Email ______________ Phone ______________

Date of last dental care ______________ Date of last x-rays ______________

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath	❑ Y ❑ N Food collection between teeth	❑ Y ❑ N Periodontal treatment	❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Bleeding gums	❑ Y ❑ N Grinding or clenching teeth	❑ Y ❑ N Sensitivity to cold	❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Clicking or popping jaw	❑ Y ❑ N Loose teeth or broken fillings	❑ Y ❑ N Sensitivity to hot	❑ Y ❑ N Sores or growths in mouth

How often do you brush? ______________ Floss? ______________

How do you feel about the appearance of your teeth? ______________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment ______________

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ______________ Relation to Patient ______________ Birthdate ______________

Address (if different from patient) ______________ Soc. Sec. # ______________

City ______________ State ______ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________

Subscriber Employed by ______________ Business Phone ______________

Business Email ______________________________

Insurance Company ______________ Phone ______________

Insurance Email ______________________________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other dependents under this plan ______________________________

Please complete both sides.