PATIENT INFORMATION

Date _____ Email _____ Cell# _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
CITY STATE ZIP CODE

Home Phone _____ Birthdate _____ Social Security# _____

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

Emergency contact _____ Relationship _____

Complete Address _____ Phone _____

RESPONSIBLE PARTY INFORMATION

Name _____
LAST FIRST MIDDLE

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address _____ Home Phone _____ Work Phone _____

Social Security# _____ Birthdate _____ Relationship to Patient _____

WORK INFORMATION

Employer _____ Occupation _____ #Years Employed _____

Employer Address _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ #Years Employed _____

Employer Address _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security# _____

Insurance Company _____ Group# _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? Yes ___ No ___ **If yes: Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Social Security# _____

Insurance Co. _____ Group# _____

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 ___

Do you or have you had TMJ / jaw problems? Yes ___ No ___

If yes, please explain symptoms _____

Date of last X-Rays _____

Is your mouth dry? Yes ___ No ___

Have you had orthodontic treatement? Yes ___ No ___

Have you had periodontal / gum treatment? Yes ___ No __

Would you like to change anything about your teeth? _____

PLEASE COMPLETE BACK PAGE