We are complimented that you have selected us to provide dental care for you and your family.

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

Patient Information

Date _____ Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Ph. # (___) _____ Work Ph. # (___) _____ Soc. Sec. # ___-___-___ Drivers Lic. # _____

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Ph. # (___) _____

Emergency Contact _____ Ph. # (___) _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Soc. Sec. #___-___-___ Birthdate ___/___/___ Relationship to Patient _____

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Ph.# (___) _____ Work Ph.# (___) _____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____ Relationship to Patient _____

Soc. Sec. #___-___-___ Birthdate ___/___/___ Work Ph.# _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (___) _____

Is policy connected with your union? Yes___ No___ Name of Union _____ Local # _____

Do you have dual coverage? Yes___ No___ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Ph. # (___) _____

Insured's Employer _____ Ph. # (___) _____

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___

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

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

Please complete back page