We are pleased 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 _____

If patient is a full-time student, fill in school name _____

School Address _____ Ph. # (___) _____

Emergency Contact _____ Ph. # (___) _____

## Responsible Party Information

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

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

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

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

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

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 # _____ Insured's DOB _____

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