PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

PERSONAL

Name____
Last First MI (Preferred)

Birthdate_________________ SS#______________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone______________________ Wireless Phone______________________

Email____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part time

If patient is a minor, who is legally responsible?____

Emergency Notification______________________________________ Phone________________________________

Occupation____Employer______________________________________

Will you receive calls at work?____________If Yes, Work Phone__________________________________

How did you hear about us?

____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address____

Address 2____

City________________________________ State________Zip______________________

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name____Subscriber ID # _________________________

Subscriber Date of Birth_______________________Subscriber Social Secuirty Number_________________________

Insurance Company ____Phone________________________________

Employer______________________________Group Name________________________Group #__________________

Please present insurance card.

DENTAL QUESTIONNAIRE

Reason for today's visit: [ ] Exam [ ] Emergency [ ] Consultation

Are you in pain?____________ How long? ____

Please indicate any of the following problems:

[ ] Discomfort, clicking or popping in the jaw [ ] Lost/broken filling(s) [ ] Stained teeth

[ ] Red, swollen or bleeding gums [ ] Teeth grinding [ ] Locking jaw

[ ] Sensitive tooth, teeth, or gums [ ] Ringing in ears [ ] Bad breath

[ ] Blisters/sores in or around the mouth [ ] Broken/chipped tooth

[ ] Other: ____

Last Dental Exam? ______________________________ Last Dental X-Rays?____________________________

Times a day do you brush? ____________ Times a week you floss? _____________

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)