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. # ________________ Driver License # ____________
Last Name First Name Initial
Address ____
City ______________ State ______________ Zip ____________ Phone ______________
Sex ☐ M ☐ F Age_____ Birthdate__________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Patient Employed by__________________________________ Occupation ____________
Business Address ______________________________ Business Phone ____________
Whom may we thank referring you? ____
Notify in case of emergency ______________________________ Phone ____________

Insurance

Person Responsible for Account ____
Last Name First Name Initial
Relation to Patient ________________ Birthdate ______________ Soc. Sec.# ______________
Address (if different from patient) ____________________________ Phone ______________
City ____________________ State ____________________ zip ______________
Person Responsible Employed by ____________________________ Occupation ____________
Business Address ____ Business Phone ____________
Insurance Company ____
Contract # ________________________ Group# ______________ Subscriber #____________
Name of other dependents under this plan ________________________________
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name ____________________ Relation to Patient ______________ Birthdate____________
Other ____

Dental History

Purpose of Appointment ______________ Is this office visit for Emergency Dental Care? ____________
Former Dentist Address ________________________________ Phone ______________
Date of last dental care ________________ Date of last full mouth X -rays ______________
Check ☑ if you have had problems with any of the following:

☐ Bad Breath ☐ Food Collection between teeth ☐ Periodontal treatment ☐ Sensitivity to Sweets
☐ Bleeding Gums ☐ Grinding or clenching teeth ☐ Sensitivity to cold ☐ Sensitivity when biting
☐ Clicking or popping jaw ☐ Loose teeth or broken fillings ☐ Sensitivity to hot ☐ Sores or growths in mouth

Have you ever had a local anesthetic (novacaine, etc.)? ☐ Yes ☐ No
Any unfavorable reaction from them? ☐ Yes ☐ No

Please complete both sides