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. # __________

Birthday ____/____/____ If patient is a minor, give parent's/guardian's name ____________________

If patient is a full-time student fill in school 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)

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) ____________________ (Street / City / State / Zip)

Social Security # __________ Birthdate __________ Relationship to Patient __________

Employer __________ Occupation __________ No. Years Employed ______

Employer Address ____________________

Spouse's Name ____________________ (Last / First / Middle) Relationship to Patient __________

Employer __________ Occupation __________ No. Years Employed ______

Employer Address ____________________

Social Security # __________ Birthdate __________ Work Ph. # (____) __________

Insurance Information

Insured's Name ____________________ Insured's Soc. Sec. # __________

Insurance Company ____________________ Group No. __________

Insurance Co. Address ____________________ Ph. # (____) __________

Is policy connected with your union? Yes ____ No ____ Name of Union __________ Local No. __________

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

Insured's Name ____________________ Insured's Soc. Sec. # __________

Insurance Co. ____________________ Group No. __________ Local No. __________

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 examination __________ 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? ____________________