PATIENT INFORMATION:

**WELCOME!**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | Cell #: | | | Date of Birth: |
| Address: | | City: | | State/Zip: |
| Home Phone: ( ) | SSN: | | | Sex: M F |
| Employer: | Phone: | | | Occupation: |
| Emergency contact: | | | Phone: | |
| When/where are the best times to reach you? : | | | | |
| Email address: | | | | |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental History

Date of Last Dental Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last X-Rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently in pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you require premedication?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious trouble associated with any previous dental treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy with the way your smile looks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, what would change?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can we thank for referring you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

Bad breath\_\_\_ Loose teeth or broken fillings\_\_ Sensitivity while biting\_\_

Bleeding gums \_\_\_ Orthodontic treatment \_\_\_ Jaw, head or neck injuries\_\_

Blisters on lips or mouth\_\_\_ Periodontal treatment \_\_\_ Jaw difficulty: clicking or pain\_\_

Grinding teeth\_\_\_ Lip or cheek biting\_\_\_ Sensitivity to cold/heat/sweets\_\_

Secondary Insurance

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate\_\_\_\_\_\_\_\_\_\_\_ SNN\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber I.D.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance

Name of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate\_\_\_\_\_\_\_\_\_\_ SNN\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber I.D.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_