PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date _____ Gender M F Date of Birth _____ Age _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Primary Phone # _____ Social Security # _____

How would you like to receive appointment reminders? ☐ Email Email address _____
☐ Text Mobile # _____

Patient's Family Dentist _____

How did you hear about our practice: _____

Names of any relatives treated here _____

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 Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ Email _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Spouse's Employer _____ Occupation _____ Email _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Subscriber ID # _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue:

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Subscriber ID # _____

Insurance Co. Address _____

Insured's Employer _____

SIGNATURE ON FILE

Signature (Parent's signature, if minor) _____ Date _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

I understand that where appropriate, credit bureau reports may be obtained.

OFFICE USE ONLY

Office: _____

DENTAL HISTORY

HAVE YOU EVER HAD THE FOLLOWING TREATMENT:	YES	NO
Orthodontic (straightening of the teeth) As a child _____, or an adult _____.		
Extractions How long ago_____ Reason for extractions _____		
Periodontal treatment		
Mouthguard or splint (plastic device between your teeth)		
Treatment or surgery to change your bite		

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

Sores, lumps or irritated areas in your mouth		
Food catching or collecting between your teeth		
Clenching or grinding your teeth		
Clicking, popping or grating noise in your jaw when chewing Does it bother you? _____		
Numbness or tingling in your mouth or face		
Would you change anything about your teeth or smile?		

Over the past five years, how often have you been seen for teeth cleaning? _____

The date of your last visit to a dentist _____.

That dentist's name _____

DATE: _____ PATIENT SIGNATURE _____