



PATIENT INFORMATION

Date ___/___/___

First Name _____ Middle Initial _____ Last Name _____ Nickname _____

Street _____ City _____ State _____ Zip _____

E-Mail address _____ SS# _____ - _____ - _____

Date of Birth ___/___/___ Age _____ Sex: Male Female Unspecified

Home # _____ - _____ - _____ Cell # _____ - _____ - _____ Employer _____ Work # _____ - _____ - _____

Single Married Divorced Widowed Other _____

Emergency Contact _____ Emergency # _____ Relationship _____

Preferred Pharmacy _____ Street _____ City _____

If Married, Spouse First Name _____ Middle Initial _____ Last Name _____

Spouse DOB ___/___/___ Spouse SS # _____ - _____ - _____ Spouse Employer _____ Cell # _____ - _____ - _____

PRIMARY DENTAL INSURANCE

Relationship to Subscriber Self Spouse Other Dependent

Subscriber First Name _____ Middle Initial _____ Last Name _____

Employer Name _____ Insurance Company _____

Ins Co Address _____ Ins Co. Phone # _____ - _____ - _____

Member ID# _____ Group # _____ **** Please provide card to receptionist****

SECONDARY DENTAL INSURANCE

Relationship to Subscriber Self Spouse Other Dependent

Subscriber First Name _____ Middle Initial _____ Last Name _____

Employer Name _____ Insurance Company _____

Ins Co Address _____ Ins Co. Phone # _____ - _____ - _____

Member ID# _____ Group # _____ **** Please provide card to receptionist****

DENTAL HISTORY

Last Dental Visit _____ Previous Dental Office _____ Date of last X-rays _____

Check all that apply Jaw Pain Sensitive Teeth Grinding/Clenching Broken/Loose Teeth Mouth Sores Perio Disease

Anesthetic Reaction Difficult Chewing/Swallowing Swollen/Bleeding Gums Stained Teeth Bad Breath Denture/Partial

Who referred you to our office? We would like to THANK them! _____

Signature _____