WELCOME

Date: _____

PATIENT INFORMATION

Name: _____ DOB: _____
Last Name First Name Initial

Address: _____

SSN: _____ E-mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: M F Status: Minor Single Married Long Term Partner Widowed Separated

Employer: _____ Occupation: _____

Business Address: _____

Who Should we thank for referring you? _____

In case of an emergency whom should we contact? _____

PRIMARY INSURANCE

Person responsible for account: _____ Relationship to Patient: _____

Contact Phone: _____ DOB: _____ SSN: _____

Address: _____

Responsible Party Employed By: _____ Business Phone: _____

Business Address: _____

Insurance Company: _____

Subscriber ID: _____ Group ID: _____

ADDITIONAL INSURANCE Yes No

Insured Name: _____ Relationship to Patient: _____

Contact Phone: _____ DOB: _____ SSN: _____

Insurance Company: _____

Subscriber ID: _____ Group ID: _____

MEDICAL INFO

Primary Care Physician: _____

Medical Group: _____ Contact Phone: _____

DENTAL HISTORY

Former Dentist: _____ Date of last X-rays: _____

City, State: _____ Date of last dental visit: _____

How often do you brush? _____ How often do you floss? _____

PLEASE CIRCLE ALL THAT APPLY:

Bad Breath…	Loose Teeth or Broken Filling…	Sensitive to sweets…	Lip or cheek biting…	Bleeding gums
Sensitive when biting…	Sensitive to heat…	Sensitive to cold…	Grinding teeth…	Tooth pain
Blisters on lips/mouth…	Finger Nail biting…	Pain around the ear…	Frequent Headaches	
Periodontal Treatment..	Orthodontic Treatment…	Jaw, head, or neck injuries		
Jaw difficulty: clicking and/or pain …		***Have you had problems with prior Treatment?***	***Yes***	***No***

(If yes, please explain) _____