Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information:

Today's Date: _____

Name: _____

Preferred or Nick Name: _____

☐ Male ☐ Female
☐ Married ☐ Unmarried ☐ Separated ☐ Widowed

(If child) Mother's Name: _____

(If child) Father's Name: _____

Address/Apt#: _____

City/State/Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Date of Birth: _____ Age:_____

Social Security #: _____

Place of Employment: _____

Emergency Contact _____
Phone Number _____

Insurance Information:

Responsible Party: _____

Relationship to Patient: _____

Employer: _____

Insurance Company: _____

Date of Birth: _____

Social Security #: _____

Complete the Following if You Have Secondary Insurance:

Responsible Party: _____

Relationship to Patient:_____

Employer: _____

Insurance Company: _____

Date of Birth: _____

Social Security#: _____

How Did You Hear About Us?
☐ Insurance ☐ Phone Book ☐ Doctor Referral ☐ A Friend

Name: _____

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-ray _____
How often do you: brush _____ floss_____ use rinses? _____
Have you ever had previous periodontal treatment? ❑ Yes ❑ No If yes, was it surgical? ❑ Yes ❑ No
Are you satisfied with the way your teeth look? ❑ **Yes** ❑ **No**

Check (✔) if you are currently having problems with any of the following:

❑ Bad Breath	❑ Grinding Teeth	❑ Sensitivity to hot
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Sensitivity to sweets
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Sensitivity when biting
❑ Food collection between teeth	❑ Sensitivity to cold	❑ Sores or growths in your mouth