Patient Information

Date:________________Patient's Name:____
Address:____
Home: (____)_____-__________Work: (____)______-___________Cell: (____)_____-_______________
Social Sec.#_____________________Drivers Lic.#__________________Email:_____________________
Birthdate:____/___/_____Sex: M F If patient is minor, give parent's/guardian's name:______________
Name of nearest relative not living with you__________________________Relationship:_____________
If patient is a full-time student, fill in school name____
School Address:_____________________________________Phone: (____)_____-__________________
Emergency Contact:__________________________________Phone: (____)_____-__________________

Responsible Party information

Name:____
Social Sec.#___________________Birthdate:_____/_____/______Relationship to patient:____________
Residence:____
Mailing Address:____
How long at this address:_______Phone: (_____)______-__________Work: (_____)______-__________
Previous Address (if less than 3years)____
Employer:____Occupation:___________________________
No. Years Employed:_______Employer Address:____

Insurance Information

Insured's Name:____Insured's DOB:_______________
Insurance Company:____Group #____________________
Insurance Co. Address:______________________________________Phone: (____)______-_________
Is this policy connected with your union? Yes No Name of union:_____________Local #____________
Do you have dual coverage: Yes No If yes: Please complete the following secondary insurance information.
Insured's Name____Insured's Soc. Sec.#_________________
Insurance Company:____________________Group #___________________Local #_________________
Insurance Co. address____Phone: (____)_____-___________
Insured's Employer:____Phone: (____)_____-__________

Dental Information

Do your gums bleed when you brush?...Yes No
Are your teeth sensitive to heat or cold? Yes No..........................Pressure: Yes No........Sweets: Yes No
Do you grind or clench your teeth?...Yes No
Do you have any fear of dental work?...Yes No
Date of last dental visit?___________________________What was done at the time?_________________
Former Dentist Name:____________________________City:_________________________________
How would you describe your current dental problem?____
How do you feel about the appearance of your teeth?____