

## Patient Information

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Res. Tel.# \_\_\_\_\_ DL # \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Marital Status S/M/D/W

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Bus.Tel# \_\_\_\_\_ Cell # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Your spouse's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Employer \_\_\_\_\_ Bus.Tel# \_\_\_\_\_ Cell# \_\_\_\_\_

Person to contact in an emergency \_\_\_\_\_ Relation \_\_\_\_\_

Res. Tel. # \_\_\_\_\_ Bus. Tel. # \_\_\_\_\_ Address \_\_\_\_\_

Party responsible for account \_\_\_\_\_ Res.Tel. # \_\_\_\_\_ Cell Tel.# \_\_\_\_\_

Reason for this visit \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### DENTAL HEALTH HISTORY

*For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL*

#### Dental History:

Previous Dentist \_\_\_\_\_ City \_\_\_\_\_ How long \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of last dental cleaning \_\_\_\_\_ Date of last full mouth x-ray \_\_\_\_\_

1. Why did you leave your last dentist? \_\_\_\_\_

2. What did you like most about any dentist, or a dental office you have been to? \_\_\_\_\_

3. What did you like least about any dentist, or dental office that you have been to? \_\_\_\_\_

### INSURANCE INFORMATION

Insured \_\_\_\_\_ Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's DOB \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Insurance Co. Tel \_\_\_\_\_ Group # \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insured \_\_\_\_\_ Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's DOB \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Insurance Co. Tel \_\_\_\_\_ Group # \_\_\_\_\_

Email Address \_\_\_\_\_

If you could change one thing about your smile, what would that be? \_\_\_\_\_

If there was a simple, inexpensive way to whiten your teeth, would you be interested? Y N

Do you want to keep your teeth? \_\_\_\_\_ Yes, no matter how much trouble \_\_\_\_\_ I don't know  
\_\_\_\_\_ Yes, if it's not too much trouble \_\_\_\_\_ I don't care