

PATIENT INFORMATION FORM

Personal Information

Last Name _____ First _____ Middle Initial _____

Name of Guardian if patient is a minor: _____

Check one: Dr. Mr. Mrs. Ms. I prefer to be called: _____

Marital status: single married child other Gender: male female

Birth Date: _____ SS#: _____

Address: _____

City _____ State _____ Zip _____

Home phone # _____ Work # _____ Cell# _____

Other # _____

Email: _____

Employer: _____ Position/Title _____ # of yrs _____

Employer Address: _____

City _____ State _____ Zip _____

Spouse's Name _____ Work #: _____ ext: _____

Other family members seen by us _____

Whom may we thank for referring you: _____

In case of Emergency contact: _____

Relation: _____ Phone #: _____

Dental Insurance

Primary Insurance Company: _____ Group#: _____

Who is the insured member in you family? Yourself Spouse Other

Insured's DOB _____ Insured's SS# _____

Insured's Employer: _____ Wk#: _____

Has the insured had previous dental care under this plan? YES NO

Secondary Insurance Company: _____ Group # _____

Insured's DOB _____ Insured's SS# _____

Insured's Employer: _____ Wk #: _____

Dental History

What was your reason for scheduling today? _____

Name of Previous Dentist: _____ Phone# _____

Date of last dental visit: _____ Date of last cleaning: _____ Date of last x-rays: _____

Have you worn braces? YES NO Orthodontist's Name: _____

Are you currently wearing your retainer every night: YES NO, why? lost broke other _____

Have you had your wisdom teeth removed? YES NO How many? _____

How often do you brush your teeth? _____

Do you floss? YES NO How often? _____

Are you happy with your teeth and their appearance? YES NO

What, if anything would you change about your teeth/smile if you could? _____

Are you interested in learning about the latest techniques in improving your smile? YES NO