

We are complimented that you have selected us to provide dental care for you and your family.  
Whom may we thank for referring you to our office? \_\_\_\_\_

### Patient Information

Date \_\_\_\_\_ Patients Name \_\_\_\_\_  
Last First Middle  
Address \_\_\_\_\_  
Street City State Zip  
Home Phone ( ) \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License # \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ If patient is a minor, give parent's/guardian's name \_\_\_\_\_  
If patient is a full-time student fill in school name \_\_\_\_\_  
Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_  
Complete Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### Responsible Party Information

Name \_\_\_\_\_  
Last First Middle Marital Status  
Residence \_\_\_\_\_  
Street City State Zip  
Mailing Address \_\_\_\_\_  
Street City State Zip  
How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Previous Address (if less than 3 years) \_\_\_\_\_  
Street City State Zip  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Ph. # \_\_\_\_\_  
Is policy connected with your union? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Union \_\_\_\_\_ Local No. \_\_\_\_\_  
Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes: **Please complete the following secondary insurance information.**  
Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Ph. # \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Ph. # \_\_\_\_\_

### 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 examination \_\_\_\_\_ What was done at that time? \_\_\_\_\_  
How would you describe your current dental problem? \_\_\_\_\_  
How do you feel about the appearance of your teeth? \_\_\_\_\_