

PATIENT INFORMATION

Patient Name: _____ Date: _____

Sex: M F Married Single Widowed Divorced Separated

Name of Spouse: _____

Father's Name (*only if patient is a child*): _____

Mother's Name (*only if patient is a child*): _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Mailing Address: (*if different from above*): _____ E-mail: _____

If Full-time Student, Name of School: _____

Patient or Father (*please indicate which*) Employed by: _____

Business Address: _____ Phone: _____

Present Position: _____ How Long? _____ Social Security No: _____

Spouse or Mother (*please indicate which*) Employed by: _____

Business Address: _____ Phone: _____

Present Position: _____ How Long? _____ Social Security No: _____

Whom may we thank for referring you? _____

Name and phone number of nearest relative not living with you: _____

Who will pay this account? _____

Names of other immediate family members who are patients: _____

In case of emergency please call: _____

Name of primary dental insurance company: _____ Employee: _____

Address for claims: _____ Policy No.: _____

Employee's date of birth: _____

Employee's address if different from above: _____

Name of secondary dental insurance company: _____ Employee: _____

Address for claims: _____ Policy No.: _____

Employee's date of birth: _____

Employee's address if different from above: _____

MEDICAL INFORMATION

Patient date of birth: _____ Age: _____

Have you ever had any serious trouble associated with any previous dental treatment? Yes No

If yes, please explain _____

Does dental treatment make you nervous? Yes No — Slight Moderate Extremely

Date of last dental visit _____ Last dental x-rays _____

Have you ever been treated for periodontal disease (*gum disease, pyorrhea, trench mouth*)? Yes No If yes, when? _____

Are you happy with your smile? Yes No

