

**PATIENT INFORMATION**

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_ If Patient is a Minor, give Parent's or Guardian's Name \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 Who May We Thank for Referring You to our Office? \_\_\_\_\_ Reason for this Visit \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 RESIDENCE Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 MAILING ADDRESS Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 PREVIOUS ADDRESS (if less than 3 yrs.) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How Long \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

**RESPONSIBLE PARTY'S SPOUSE**

NAME \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ OCCUPATION \_\_\_\_\_ MIDDLE \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_  
 SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
 HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_  
 WORK PH. \_\_\_\_\_ E-MAIL \_\_\_\_\_

**EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY, STATE \_\_\_\_\_  
 HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_  
 WORK PH. \_\_\_\_\_

**DENTAL INSURANCE INFORMATION (Primary Carrier)**

Insured's Name \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

**If you have double dental insurance coverage, complete this for the second coverage.**

Insured's Name \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

*DENTAL HISTORY*	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>
WHAT?		
Is your present dental health POOR?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (Partial or Full)	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn BRACES on your teeth (ORTHODONTICS)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>
Name of previous Dentist:		
City: _____ State: _____		
How do you feel about your teeth?		
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.		
FEAR of pain # _____	LACK of concern # _____	
COST of treatment # _____	MISSING work time # _____	

**FAMILY PHYSICIAN:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_  
 (or guardian of Minor)

**DATE:** \_\_\_\_\_