Welcome!

PATIENT INFORMATION

Name(Last)_____
(First)_____
(Middle)_____
Social Security #_____
Driver's License#_____
BirthDate_____
Home Phone_____
Work Phone_____
Cell Phone_____
Address_____
City_____State_____Zip_____
Email_____

Parent/Guardian Information

Name(Last)_____
(First)_____
Relationship to Patient_____
Phone_____

EMERGENCY CONTACT

Name_____
Relationship_____
Phone_____

EMPLOYMENT INFORMATION

Employer_____
Occupation_____
EmployerAddress_____
Employer Phone#_____

DENTAL INSURANCE

SubscriberName_____
Subscriber Social Security#_____
Subscriber Date Of Birth_____
Name Of Ins.Company_____
Group #_____
ID#_____
Phone#_____

ARE YOU COVERED BY ANOTHER PLAN? IF SO, PLEASE FILL OUT THE FOLLOWING SECTION

SubscriberName_____
Subscriber Social Security#_____
Subscriber Date Of Birth_____
Name Of Ins.Company_____
Group #_____
ID#_____
Phone#_____

DENTAL HISTORY

ReasonForToday'sVisit_____
Date OfLastDentalVisit_____
Date of last X-rays_____

Circle if you have had a problem with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Food Collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Sensitivity to Cold/hot/sweet
- ☐ Clicking Jaws
- ☐ Sesitivity to biting
- ☐ Sores or Growth in your Mouth

Are you satisfied with your teeth and their apperance?

☐ Yes or No

If no, how can we help improve their apperance?

PLEASE CHECK ONE

How did you hear about our office?

- ☐ Banner
- ☐ Insurance
- ☐ Friend /Relative/Family

Whom may we thank for reffering you_____

48 Hour Cancellation Policy: Initial_____
$25 charge will apply
$100 charge For Speciality Appts.

X-RAYS AND EXAM

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I undertand that while x-rays are taken of my teeth that I will be exposed to a minimal amount of radiation as part of the necessary requirments to complete a through and comprehensive examination. I also understand that if I am pregnant radiation exposure posses a serious threat to the life and health of my unborn child. Pregnant women are required to have medical release from their Medical Doctor prior to x-rays and dental treatment.

Initial_____

NOTICE OF PRIVACY AND DENTAL MATERIALS FACT SHEET

I acknowledge that a copy of Dental Materials Fact Sheet And Notice of Privacy Practices have been given to me.

Initial_____Date_____