## Patient Information

**DATE:**

Patient Name: _____
Last, First MI (Preferred Name)

SS#: _____ DOB: _____ DL#: _____

Address: _____ _____
Street Apartment #

_____
City State Zip Code

**We now confirm appointments by email and/or text.**

EMAIL: _____ Cell: _____

Home: _____ Work: _____ ext: _____

Employer: _____ Occupation: _____

Name of person or office referring you to our practice? _____

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ SS#: _____ DOB: _____

Address: same as above? Y N If No, please fill out the following:

_____
Street Apartment #

_____
City State Zip Code

Employer: _____ Occupation: _____

## Insurance Information

**IF YOU HAVE A DENTAL INSURANCE CARD- please let the front office make a copy and you can skip this next step. If no dental card is present, please fill out as best as you can. Thank you.**

Insurance Carrier: _____ ID#: _____

Group #: _____ Customer Service Phone #: _____

Claim Mailing Address: _____
_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

## Dental History

| | | |
|---|---|---|
| Are healthy teeth and gums important to you? | YES | NO |
| Can you chew your food without pain or sensitivity? | YES | NO |
| Do your gums bleed when you brush or floss? | YES | NO |
| Do your teeth hurt? | YES | NO |
| Are you aware of any chipped or broken teeth? | YES | NO |
| Are you happy with the way your teeth look? | YES | NO |