

Patient Information

Name _____ M or F (Circle One)

Home Phone _____ Cell Phone _____ E-Mail Address _____

Home Address _____ City _____ Zip _____

SS No. _____ Employer _____

Business Address _____ City _____ Zip _____ Bus. Phone _____

Date of Birth _____ Weight _____ Height _____ Single _____ Married _____ Divorced _____ Widowed _____

Spouse (If Applicable)

Spouse's Name _____ SS No. _____ DOB _____

Occupation _____ Employer _____

Business Address _____ City _____ Zip _____ Bus. Phone _____

Parents (If Patient is Under 18)

Mother's Name _____ SS No. _____ DOB _____

Address (if different from patient) _____

Occupation _____ Employer _____

Business Address _____ City _____ Zip _____ Bus. Phone _____

Father's Name _____ SS No. _____ DOB _____

Address (if different from patient) _____

Occupation _____ Employer _____

Business Address _____ City _____ Zip _____ Bus. Phone _____

Person Responsible for Account

Name _____ SS No. _____

Dental Insurance Carrier and I.D. No. _____

Referred by: (we like to say 'Thank You') _____

Dental History

1. When did you have your last Dental Examination? _____ Where? _____
Was treatment recommended? _____ What treatment was recommended? _____
Was treatment completed? _____ If not, why? _____
 2. What problems have you had with your teeth? _____
 3. Are you pleased with the appearance of your teeth? _____
 4. Is there any particular treatment you would like us to discuss? _____
 5. What do you feel the condition of your mouth is now? _____
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