

WELCOME DENTAL

How did you hear about us? _____

Patient Information

Date _____ Name _____

Address _____

Home Phone _____

Birthdate _____

Work Phone _____

Social Security # _____ - _____ - _____

Cell Phone _____

E-Mail _____

Drivers License # _____

Student Status information if patient is a full time student.

School Name _____ City _____

Emergency Contact Information:

Name _____ Relationship _____

Address _____

Phone Number _____ Email _____

Responsible Party Information (If other than patient)

Name _____ Birthdate _____

Address _____ Social Sec. # _____ - _____ - _____

Phone Number _____ Work Number _____

Dental Insurance Information

Primary:

Policy Holder: Name _____ Employer _____

Birthdate _____ Phone # _____

Social Security # _____

Dental Insurance Company _____

Group Number _____

Secondary (if applicable):

Policy Holder: Name _____ Employer _____

Birthdate _____ Phone # _____

Social Security # _____

Dental Insurance Company _____

Group Number _____

Dental Information

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to: Please circle.

Heat or Cold _____ Pressure _____ Sweets _____ Other _____

Do you grind your teeth? Yes ___ No ___

Do you have any fear of dental procedures? Yes ___ No ___

Date of last visit to a dentist _____ What was done? _____

Do you like your teeth and/or your smile? _____

Anything you would like us to know? _____