

WELCOME TO OUR PRACTICE!

Please complete this questionnaire carefully. The information is confidential and helps us provide you and your family with complete, quality dental care.

Patient's Name _____ Date of Birth _____
Sex: M F Marital Status: S M Div Sep Widow (Circle) SS# _____

Address _____ City _____ Zip _____
Home# _____ Work # _____ Cell# _____
Email address: _____ Place of Employment _____

Student Status: (circle) Full Time or Part Time or None Attending _____
Whom may we thank for referring you? _____

Responsible Party (if different from patient) _____ Billing Address if
Different _____ City _____ Zip _____
Their place of employment _____

DENTAL INSURANCE INFORMATION

Name of Insurance Co and Mailing Address _____

Name of person that insurance is carried under _____
Their SS# _____ Their date of birth _____
Group# _____ ID# _____ Telephone # of ins. Co _____
Who is covered on this policy? _____

Do you have secondary coverage? ___ Through Whom ? _____ ID # _____
Group # _____ ID# _____ Telephone # of ins company _____
Date of Birth: _____ Which family members are on this secondary
policy? _____

DENTAL HISTORY

Date of last dental exam _____ Previous Dentist _____
Reason for last dental visit _____ May we request your records? _____
How many times a day do you brush your teeth? _____ Do you floss daily? _____
Do your gums bleed when you brush ? _____ Would you like whiter teeth? _____
Do you feel your fillings are unattractive? _____ Would you like straighter teeth? _____
Do you have dental implants? _____ Do you wear dentures or partials? _____
Have you ever had an unusual reaction to dental anesthetic? ___ if yes please explain

Reason for seeking treatment today _____

Any additional information you feel would be helpful with your visit today _____