WELCOME TO OUR OFFICE

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank you and we are glad you are here!

ABOUT PATIENT

Today's Date: _____ E-Mail Address: _____

Patient's Name: _____ Date of Birth: _____-_____-_____
Last First MI Age: _____

Preferred Name/Nickname: _____ Male Female

Social Security Number: _____ -_____-_____ Home Number: (_____) _____-_____

Home Address: _____ Work Number: (_____) _____-_____

City: _____State: _____Zip:_____ Cell Number: (_____) _____-_____

Single Married Divorced Widowed Separated **Can we text appointment information to your cell phone? Y N**

Employer Name: _____ Occupation: _____

Employer Address: _____ How long employed there? _____

City: _____State: _____Zip:_____ **How did you hear about us?** _____

SPOUSE INFORMATION

His/Her Name: _____ Employer: _____

Date of Birth: _____-_____-_____ SS#:_____-_____-_____ Work #: (_____) _____-_____

Cell #: (_____) _____-_____

DENTAL INSURANCE INFORMATION

Name of **Employee**: _____ Name of **Employer**: _____

Patient's Relationship to the employee: _____ Insurance Co. Name: _____

Employee's ID#:_____ Address: _____

Employee's DOB: _____-_____-_____ _____

Group#_____ Phone # for customer service: (_____) _____-_____

DENTAL HISTORY

How many times per day do you brush your teeth? _____ Do your gums ever bleed? Yes No

Do you floss your teeth? Yes No Do you use mouthwash? Yes No

Have you had orthodontic treatment in the past? Yes No Do you currently wear any retainers or nightguards? Yes No

Do you have any dental concerns today? Yes No _____

How long since your last dental visit? _____ Name of previous dentist: _____

Why did you leave your last dentist?_____