PATIENT INFORMATION

Patient's Name ______________________ S.S. # ________________ Birth date _________ Age _____

Responsible party if patient is a minor ______________________________ Relation ________________

Address ____ Home Phone ______________________

City ___________________ State ______ Zip Code _________ Cell Phone _______________________

Employer _____________________ Occupation __________________ Work Phone _________________

INSURANCE 1ST COVERAGE		INSURANCE 2ND COVERAGE	
Employee Name ______________________		______________________	
Employer ________________	#yrs. _____	______________________	#yrs. _____
Name of Insurance Co. ______________		______________________	
Program or Policy # ________________		______________________	
Union Local ________________________		______________________	
Social Security Number _____________		______________________	
Birth date _________________________		______________________	

LIST REMAINING PERSONS TO APPEAR ON THIS ACCOUNT:

FULL NAME	BIRTH DATE	AGE	M / F

In Case of Emergency: Name, address, and phone number of nearest relative not living with you:

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____

IN CONSIDERATION OF THE SERVICES RENDERED TO ME BY THIS DENTAL CENTER, I AM OBLIGATED TO PAY SAID DENTAL CENTER IN ACCORDANCE WITH ITS CREDIT TERMS AND POLICIES.

PATIENT'S SIGNATURE ____________________________________ DATE _______________

If patient is a minor, guardian or parent must sign

DENTAL HISTORY

Referred by ____

Previous Dentist ____

Date of last dental check up and / or cleaning ___________________________________

Why are you seeking dental care? ____

____

How often do you… Brush? ________________ Floss? ______________ See Dentist ________________

What would the loss of your natural teeth mean to you? _______________________________

____

DO YOU HAVE ANY OR HAVE YOU EVER HAD: (circle)

1. Head or neck injuries----------------------------- Yes/No
2. Sore or sensitive teeth--------------------------- Yes/No
3. Bleeding gums------------------------------------ Yes/No
4. Grind or clench teeth----------------------------- Yes/No
5. Difficulty chewing--------------------------------- Yes/No
6. Anxiety of dental treatment--------------------- Yes/No
7. Sores on lips or mouth that are slow to heal Yes/No
8. Orthodontics treatment-------------------------- Yes/No
9. Periodontal Disease (Pyorrhea)---------------- Yes/No
10. Trouble open / close jaw point----------------- Yes/No
11. Reactions with "novocaine"--------------------- Yes/No
12. Bleeding, slow healing after tooth extraction Yes/No
13. Dissatisfaction with appearance--------------- Yes/No
14. When was your last dental x-ray taken? _______