

Patient Information

Date _____		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Student <input type="checkbox"/> Child	
Last Name _____		First Name _____ Middle _____	
Date of Birth _____		Social Security Number _____	
Address _____		City _____ State _____ Zip _____	
E-Mail _____		Home # _____	
Work # _____		Cell # _____	
Employer _____		Phone # _____	
If patient is a minor, give parents or guardian's name _____			
Name of nearest relative not living with you _____			
Complete Address _____		Phone # _____	
Whom may we thank for referring you to our office? <input type="checkbox"/> Patient _____			
<input type="checkbox"/> Mailing to Home (List Publication) _____ <input type="checkbox"/> Location <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____			

Responsible Party Information

Last Name _____		First Name _____		Middle _____	
Date of Birth _____		Social Security # _____		Relationship to Patient _____	
Address _____		City _____		State _____ Zip _____	
Home # _____		Work # _____		Cell # _____	
Previous Address (if less than 3 yrs.) _____					
Employer _____		Occupation _____		No. Years Employed _____	
Address _____		Phone # _____			
Spouse Information					
Last Name _____		First Name _____		Middle _____	
Date of Birth _____		Social Security # _____		Relationship to Patient _____	
Address _____		City _____		State _____ Zip _____	
Home # _____		Work # _____		Cell # _____	
Employer _____		Occupation _____		No. Years Employed _____	
Address _____		Phone # _____			

Dental Insurance Information

Primary Dental Insurance	Secondary Dental Insurance
Insured's Name _____	Insured's Name _____
Insured's Date of Birth _____	Insured's Date of Birth _____
Insured's Phone # _____	Insured's Phone # _____
Insured's Social Security # _____	Insured's Social Security # _____
Insurance Company _____	Insurance Company _____
Company Address _____	Company Address _____
_____	_____
Insurance Company Phone # _____	Insurance Company Phone # _____
Insured's Employer _____	Insured's Employer _____

Dental Information

Do your gums bleed when you brush? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat or cold? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are your teeth sensitive to Pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a fear of the dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you grind or clench your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had your teeth bleached before? <input type="checkbox"/> Yes <input type="checkbox"/> No
How do you feel about the appearance of your teeth? Do you: <input type="checkbox"/> Love them <input type="checkbox"/> Accept them <input type="checkbox"/> Want to change them	
How do you feel about the appearance of your smile? Do you: <input type="checkbox"/> Love it <input type="checkbox"/> Accept it <input type="checkbox"/> Want to change it	
Date of Last Examination _____ What was done at that time? _____	
Are you interested in using Nitrous Oxide (Laughing Gas) <input type="checkbox"/> Yes <input type="checkbox"/> No	