Welcome

1

about you

Today's Date: / /	File #:	
Patient Name:		
LAST	FIRST	M.I.
What You Prefer To Be Called	:	Male 🗌 Female
Birthdate: / / Age:	: SS#:	
Mailing Address:		
CITY	STATE	ZIP
Home Phone #:()		
Work Phone #:()		
Cell Phone #:()		
E-Mail /Address:		
Referred by:(If doctor, please give	phono number 8.	addracs)
Phone #: ()		
Address:		
CITY	STATE	ZIP
Employer:	How Long	
Employer's Address:	12.0-10.012-10.0-10.0	
CITY	STATE	ZIP
Occupation:		
Status: Minor Single	☐ Married	Divorced
Separated Wi	dowed	
Spouse's Name:		
Do you have children? Ye		

Primary Dental Insurance		
Company Name:		
Address:		
CITY	STATE	ZIP
Phone #: ()		
Insured's ID#:		
Group # (Plan, Local, or Policy #):		
Insured's Name:		
Relation:		
Insured's Employer:		
Secondary Dental Insurance		
Company Name:		
Address:		

Phone #: ()

Group # (Plan, Local, or Policy #) :

Insured's Employer:

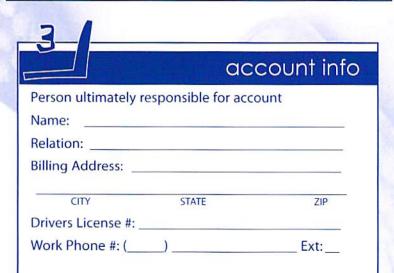
Date of Birth: __ /__ /__

CITY

Relation:

Insured's ID#:

Insured's Name:



in event of emergend

Whom should we contact?	
Relation:	
Home Phone #:()	
Work Phone #:()	Ext:
Cell Phone #:()	
Who is your Medical Doctor	
Medical Doctor's Phone #: ()	

please continue on back

							C	ler	nta	l in	ıfo	rm	atior
Do you require pre-mo		☐ Yes						(now	/				
Last Dental exam:	NAME /	1	Last D	enta	ıl X-ı	rays	:		/		_/_		
Times a day you brush													
What type of tooth bri	ush bristles	s do you us	e?		Soft			Medi	um		Ha	ard	
How would you rate ye	our smile?	(circle one)	(Worst)	1	2	3	4	5	6	7	8	9	10 Best

	medi	cal history
	Y N Heart Murmur Y N Liver Problems Y N Hepatitis Y N Chemot Y N Rheumatic Fever Y N Respiratory Problems Y N HIV+/AIDS/ARC Y N Asthma Y N Mitral Valve Prolapse Y N Sinus Problems Y N Arthritis/Rheumatism Y N Difficulty Br	Yes No edures? tic Surgery Cobalt Treatment herapy reathing /Hypoglycemia ia Blood Pressure Problems na
	Are you allergic to any of the following? Latex Penicillin/Amoxicillin Tetracycline Dental Anesthetics Foods: Others: Are you Pregnant? Yes/How long? No	
on a fr Our po been r	te you to discuss with us any questions regarding our services. The best Dental health services are based iendly, mutual understanding between provider and patient. licy requires payment in full for all services rendered at the time of visit, unless other arrangements have nade with the business manager. If account is not paid within 90 days of the date of service and no financial	UPDATE (OFFICE USE) Initials Date
any ot	ements have been made, you will be responsible for legal fees, collection agency fees, interest charges and her expenses incurred in collecting your account. rize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the er to release any information required to process insurance claims.	Comments
provid		I .