

PATIENT INFORMATION

Patient's Name _____ S.S.# _____ Birthdate _____ Age _____

Responsible party if patient is a minor _____

Address (Res) _____

City _____ State _____ Zip _____ Home Phone _____

Employer Mr. _____ Occupation _____ Mr. Wk Phone _____

Employer Mrs./Ms. _____ Occupation _____ Mrs./Ms. Wk Phone _____

INSURANCE 1ST COVERAGE

INSURANCE 2ND COVERAGE

Employee Name _____

Employer _____ #yrs. _____

Name of Insurance Co. _____

Program or Policy # _____

Union Local _____

Social Security Number _____

Birthdate _____

_____ #yrs. _____

Social Security Number _____

Birthdate _____

LIST REMAINING PERSONS TO APPEAR ON THIS ACCOUNT:

FULL NAME

BIRTHDATE

AGE

M/F

In case of emergency; Name, address and phone number of nearest relative not living with you:

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.

TODAY'S DATE _____ PATIENT'S SIGNATURE _____

If patient is minor, guardian or parent must sign.

DENTAL HISTORY

Referred by _____

Previous Dentist _____ City _____ How long _____

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 OR HAVE YOU EVER HAD: (circle)

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