Patient Information

Date ______________ Soc. Sec. No.________________ Birthdate _____________ Driver's Lic. No.____________

Name ____
Last Name First Name Initial

Address ____________________________ City, State, Zip: ____

Confirm Appointments by: □ **Email** □**Text** □**Call** (please check all that apply)

Email Address: _________________________________

Home Number: _________________________________ Cell Phone: ____________________________

Employer _________________________________ Business Phone ________________ Ext __________

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

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Primary Insurance

Policy Holder ____
Last Name First Name Initial

Relationship to Patient _______________ Birthdate _____________ Soc. Sec. No. ______________________

Address ____ Home Phone: ____________________

City, State, Zip: _______________________________________ Drivers Lic No: _______________________

Policy Holder Employed By ____________________________ Business Phone ____________________

Insurance Company ____________________________ Insurance Address ________________________

Subscriber I.D.#____________________________________ Group # _____________________________

Secondary Insurance

Policy Holder ____
Last Name First Name Initial

Relationship to Patient _______________ Birthdate _____________ Soc. Sec. No. ______________________

Address ____ Home Phone: ____________________

City, State, Zip: _______________________________________ Drivers Lic No:_______________________

Policy Holder Employed By ____________________________ Business Phone ____________________

Insurance Company ____________________________ Insurance Address ________________________

Subscriber I.D.#____________________________________ Group # _____________________________

Former Dentist________________________ Date of last X-Rays___________________________
City, State___________________________ How often do you floss?_______________________
Date of last dental visit_____________ How often do you brush?_______________________

Please check all that apply:

Bad Breath......... ....□	Loose Teeth or Broken Filling........ □	Sensitivity to Sweets................□
Bleeding Gums...................□	Orthodontic Treatment.....................□	Sensitivity When Biting.............□
Blisters on Lips or Mouth... □	Pain Around Ear........................... □	Frequent Headaches..............□
Finger Nail Biting..............□	Periodontal Treatment..................... □	Jaw, Head or Neck Injuries.......□
Grinding Teeth..................□	Sensitivity to Cold......................... □	Jaw Difficulty: Clicking/Pain..... □
Lip or Cheek Biting........... □	Sensitivity to Heat......................... □	Tooth Pain...........................□

Who should we thank for referring you?____
In case of emergency, who should we contact?____

PLEASE COMPLETE REVERSE SIDE