

PATIENT INFORMATION

First Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name: _____	Preferred Name: _____
Address: _____	Date of Birth: _____
_____	SSN _____
City, State, Zip: _____	Email _____
Home Phone _____	Person Responsible for Account: _____
Cell Phone _____	Emergency Contact & Phone: _____
Work Phone _____	_____
Referred by: _____	_____

DENTAL INSURANCE

Dental Insurance 1: _____	Policy Holder: _____	DOB: _____
Employer: _____	Group #: _____	ID/SSN: _____
Dental Insurance 2: _____	Policy Holder: _____	DOB: _____
Employer: _____	Group #: _____	ID/SSN: _____

DENTAL HISTORY

Reason for today's visit _____	Mark "yes" or "no" to indicate if you have had any of the following:			

Former Dentist _____				
City/State _____				
Date of last dental visit _____				
Date of last dental X-Rays _____				
			YES	NO
	Bad breath	[]	[]	[]
	Bleeding gums	[]	[]	[]
	Clicking or popping jaw	[]	[]	[]
	Dry mouth	[]	[]	[]
	Grinding teeth	[]	[]	[]
	Gums swollen or tender	[]	[]	[]
	Loose teeth or broken fillings	[]	[]	[]
	Periodontal treatment	[]	[]	[]