PLEASE PRINT

Today's date ____

Patients name ____

Sex _____________ Birth date ____

Married ______ single ______ divorced ______ widowed ______

Address ____ ZIP Code ____________________

Home phone _____________________________________ business phone ______________________________________

Best daytime phone number____

Email address____

Patient's employment at ____

Present position ____ How long held _______________

Spouse's name ____ Spouse's birth date ______________________

Spouse's employment ____

Referred by____

Purpose of call ____

Person responsible for this account____

Name of dental insurance ____

Policy number____

Social Security number of policy holder____

FOR OFFICE USE ONLY

Last dental visit____ What services____________________________________

Did you have x-rays?_______________ Regular visits?_________ Have you lost teeth?_______ Why? ________________

Missing teeth replaced by Fixed Bridge?________________ Partial? ________________ Denture? _______________

How often do you brush your teeth?________________________ Do you floss or use other aids?___________________

Gums bleed?______________ When?____

Are your teeth sensitive?___________________ Sweets?____________ Hot?____________ Cold?_______________

Are you pleased with the appearance of your teeth?____

Blood pressure____ Pulse______________________________________