



Date \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Last First Initial

Cell Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_ How do you prefer to be contacted?  Cell  Home  Work  Email

Address \_\_\_\_\_  
Street City State Zip

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_ Status  Single  Married  Widow  Divorced

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_  
Street City State Zip

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_  
Name Phone Number

**PRIMARY INSURANCE**

Subscriber \_\_\_\_\_  
Last First Initial

Relation to Patient \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from above) \_\_\_\_\_  
Street City State Zip

Subscriber's Employer \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_  
Street City State Zip

Insurance Company \_\_\_\_\_ Contract# \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber# \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

**ADDITIONAL INSURANCE**

Is patient covered by additional insurance?  Yes  No

[Continued on next page]



Are you required to take antibiotic before dental work?  Yes  No What do you take? \_\_\_\_\_

Allergies. List any allergies you have: \_\_\_\_\_

Check (√) if you have had any of the following:

- Anemia
- Arthritis
- Artificial Heart Valve
- Artificial Joints
- Asthma
- Back Problem
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Cortisone Treatment
- Cough, persistent
- Cough up blood
- Diabetes
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart problems
- Hemophilia
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Jaw Pain
- Kidney Disease
- Liver Disease
- MVP
- Pacemaker
- Pregnant
- Radiation Treatment
- Respiratory Disease
- Scarlet Fever
- Shortness of Breath
- Skin Rash
- Stroke
- Swelling of feet
- Thyroid Problems
- Tobacco Habit
- Tonsillitis
- Tuberculosis
- Ulcer
- Venereal Disease

**SMILE EVALUATION**

Do you like the appearance of your teeth?  Yes  No

Do you like the color of your teeth?  Yes  No

Are your teeth chipped or cracked?  Yes  No

Are you interested in straightening your teeth?  Yes  No

If you could change the appearance of your smile, what would you like to do? \_\_\_\_\_

**AUTHORIZATION**

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_