Patient Information

Mr. Mrs. Ms. (Please circle one) Today's Date: ____________

Name: ____________ Home Phone: ____________
Last First MI

E-Mail: ____________ Work Phone: ____________

Address: ____________

City: ____________ State: ____________ Zipcode ____________

Patients Birthdate: ____________

Immediate Dental concerns? ____________

Insurance Information

Name of person who carries the insurance: ____________

Employer of Insured: ____________ Occupation of Insured: ____________

Insured's Birthdate: ____________ Insured's Social Security Number: ____________

Dental Insurance Company Name: ____________

Insurance Group/R/Local Number: ____________

Insurance Certificate Number: ____________

Do you have other Dental Insurance? ____________

If yes, please write information here: ____________

____

Whom may we thank for referring you to our office? ____________

Do you wish your teeth were whiter? ____________

Do you have any specific wants, wishes or needs for your teeth or mouth? ____________

____

Do you grind or clench your teeth at night or during the day? ____________

Do you wear a Night Guard? ____________