



Date _____

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: Male Female Birth Date _____ Age _____ S.S. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No

Dentist _____ Medical Doctor _____ Referred By _____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Marital Status Single Married Separated Divorced Widowed

Nearest relative not living with you _____ Tel. (_____) _____
FIRST NAME LAST NAME

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card

Who will be responsible for your account?

(If self, skip to next section)

Self Spouse Father Mother Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ S.S.# _____ Birth Date _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

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PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ CITY _____ STATE _____ ZIP _____
ADDRESS

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ Tel. (_____) _____
ADDRESS

CITY _____ STATE _____ ZIP _____

Group # _____ Group Name _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: M F Birth Date _____

Address _____

CITY _____ STATE _____ ZIP _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

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SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ CITY _____ STATE _____ ZIP _____
ADDRESS

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ Tel. (_____) _____
ADDRESS

CITY _____ STATE _____ ZIP _____

Group # _____ Group Name _____

Insured Party _____ Relation _____
FIRST NAME LAST NAME

Sex: M F Birth Date _____

Address _____

CITY _____ STATE _____ ZIP _____

Tel. (_____) _____ S.S. # _____

I.D. # _____



NAME _____ AGE _____ M F PATIENT # _____
FIRST LAST SEX SOCIAL SECURITY #

DENTAL HISTORY

Referring Dentist _____ City _____
FIRST NAME LAST NAME

Briefly describe your problem: _____

How long have you had this problem? _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)

Check (X) all that apply:

PAIN: Never (If checked, go to SWELLING)
 In the Past Today

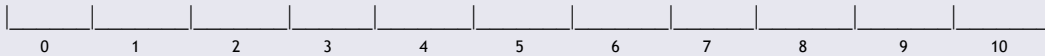
LOCATION : Upper Left Upper Right Upper Front
 Lower Left Lower Right Lower Front

DURATION: Seconds Minutes Hours Constant QUALITY: Dull pain Throbbing pain Sharp pain

PAIN SCALE (check (X) 0-10):

Mild

Severe



PROVOKED BY: Cold Hot Biting Sweet Spontaneous (unprovoked) Other _____

SWELLING: None In the Past Today Today's Anxiety Level: (0-10) _____

I have answered above completely and accurately.

Signature (patient or parent/guardian) _____ Date _____

Doctor signature _____ Date _____