Patient Information:

Name:		Birthdate:	
Preferred Name:		Gender:	
Social Security Number:		Pronoun:	
Referred by:			

Contact Information:

Street Address:	
City, State, Zip:	
Email:	
Mobile phone:	
Home phone:	
Work phone:	

Emergency Contact Information:

Name:	
Relationship:	
Phone Number(s):	

Employment Information:

Employer Name:	
Employer Address:	

Dental Insurance Information:

Primary Insurance:

Insurance Name:			
Insurance Address:			
Employer:		Insurance ID:	
Subscriber Name:		Group Number:	
Subscriber Street Address:		Subscriber DOB:	
Subscriber City, State, Zip:		Relationship:	
Subscriber Phone:		Subscriber SSN:	

Secondary Insurance: (if applicable)

Insurance Name:	
Insurance Address:	

Employer:		Insurance ID:	
Subscriber Name:		Group Number:	
Subscriber Street Address:		Subscriber DOB:	
Subscriber City, State, Zip:		Relationship:	
Subscriber Phone:		Subscriber SSN:	

Responsible Party/Guarantor:

***Complete if someone other than the patient is the person responsible for billing on your account.**

Name:	
Address:	
Phone:	
Email:	
Relationship:	
Employer:	

Dental Health History:

Previous Dentist Name:		
Previous Dentist Address:		
Previous Dentist Phone:		
Date of last dental office visit:		
Do you have images or X-rays from your previous dentist?		Yes / No
On a scale from 1-5, 5 being most terrified, how fearful are you of dental treatment?		
Are you concerned about the appearance of your smile?		Yes / No
Have you had braces, orthodontic treatment or bite adjustment?		Yes / No
Do you have problems with your jaw joint? (TMJ, popping, clicking, etc.)		Yes / No
Do you have any teeth sensitivity?		Yes / No
Do your gums bleed when brushing or flossing?		Yes / No
Have you ever experienced or been told that you have gum recession or gum disease?		Yes / No
Do you have any immediate concerns you would like us to address?		Yes / No
If yes, please provide us with information you'd like to share:		

Patient Signature: _____ Date: _____