

PATIENT INFORMATION

We apologize for the time and effort it takes to answer all of these questions but we must have all the information that is applicable before we begin treatment. Please be assured all information is held in complete confidence. If there are any questions or problems please discuss them with us.

Please complete all information and sign where indicated.

Name _____ Age _____ Single _____ Married _____ Divorced _____ Separated _____ Widow _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Business Phone ^X _____ Ext. _____ Cell Phone _____ Social Security Num. _____ Date of Birth _____ Sex _____

Who may we thank for referring you to our office? _____

Employed by _____ Employer's Address _____

Occupation or Present Position _____ How long _____ Dental Insurance Carrier _____ Plan I.D. # _____

Name of Spouse _____ Spouse Employed by _____ Employer's Address _____

Business Phone _____ Occupation or Present Position _____ Yrs. Held _____ Name of Dental Insurance Carrier _____

Spouse's Social Security No. _____
Name of financially responsible party _____

PREVIOUS DENTAL EXPERIENCE

Date of last dental exam _____ Name of previous dentist _____ City _____ State _____ Phone # _____

Reason for leaving? _____ Would you like us to request previous x-rays? _____

What features of your last dental office did you like? _____

What aspects of your last dental office did you NOT like? _____

Is there anything our office can do that would make your dental experience more pleasant? _____

