PATIENT INFORMATION FORM

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☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. _____ How do you prefer being addressed? _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Age: _____ Birth Date: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D Email: _____

Reason for Visit: _____

Employer: _____ Occupation: _____ How Long: _____

Business Address: _____ City: _____ Zip Code: _____

Business Phone: _____ Spouse Name: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Dental Policy Holders Name: _____ SSN of Policy Holder: _____

Dental Insurance Company: _____ Group Number: _____

Secondary Insurance: _____ SSN of Policy Holder: _____

Second Insurance Policy Holders Name: _____ Group Number: _____

Name of Dentist: _____ How Long: _____ City: _____

Name of Physician: _____ Physician's Phone: _____

DENTAL HEALTH

Are you in pain? _____ If YES, how long and where? _____

Do you have: ☐ Difficulty Chewing ☐ Loose Teeth ☐ Bleeding Gums ☐ Sore Gums ☐ Any TMJ Pain and/or Problems

Do you wear a bite guard? _____ How Long: _____ Have you ever had your bite adjusted or TMJ treated? _____

Have you had Periodontal treatment in the past? _____ If yes, who and when? _____

When was your last teeth cleaning? _____ Where: _____ How long before that cleaning? _____

How often do you see your dentist? _____ How many times a day do you brush your teeth? _____ Do you floss? _____

Are there any other tooth cleaning instruments you use? _____

Are you apprehensive or anxious about dental care? _____

I UNDERSTAND AND AGREE THAT I AM THE RESPONSIBLE PARTY FOR THE PAYMENT OF FEES INCURRED FOR TREATMENT, REGARDLESS OF DENTAL INSURANCE.

Signature: _____ Date: _____