Adult Patient Information

Date _____/_____/_____

Patient Name: Last:_____ First:_____ Middle I:_____

I prefer to be called:_____ M: ____ F: _____ Other: ____

Mailing Address: _____ City:_____ State:____ Zip:_____ Apt#:____

Home #: _____ Work #: _____ Cell #:_____

E-mail: _____ Birthdate: ____/____/_____ SS#: _____-_____-_____

Employer:_____ Occupation: _____ No. Years Employed: _____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ *(check one)*

***Whom may we thank for referring you to our office*? _____**

Emergency Contact Information

Name:_____ Cell #: _____ Relation:_____

Spouse Information

Spouse's Name: _____ Birthdate: __/____/__ SS#:____-____-____

Cell #: _____ Employer: _____ Occupation: _____

Dental Insurance Information

Primary Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Insured's name:_____ Insured SS#: _____-____-_____

Insured Birthday: _____/_____/_____ Relationship to patient: _____

Does Patient have Dual Coverage? Yes ____ No ____ (If Yes fill out Secondary Insurance)

Secondary Insurance Company: _____ Group #: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Insured's name:_____ Insured SS#: _____-____-_____

Insured Birthday: _____/_____/_____ Relationship to patient: _____

Dental History

Why have you come to the dentist today?_____

Are you currently in pain? _____ Do you experience bleeding gums? _____

How often do you brush your teeth? _____ Do you floss your teeth? Y_____N_____

How many times a week? _____Do you feel your teeth are sensitive? _____

Have you experienced pain or noise coming from your jaw/TMJ joint? _____

Are you aware of clenching or grinding your teeth? _____

Have you had any injuries to your face, mouth, or teeth? _____

Tobacco Use? If so, what kind and how much? _____

Former Dentist_____ City/State_____