

Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. Thank you and we are glad you are here!

Patient's Name:	Date of	Birth: -	
(Last, First MI) Preferred Name:	Age:		Female: 🗆
Social Security Number:	Home Number:	()	
Home Address:	Work Number:	()	
City:State:Zip:	_ Cell Number:	()	
Marital Status: Single: □ Married: □ Divorce	d: □ Widowed: □	Separated:	
Can we text appointment information to your cell phone? Y	: N: Email?	Y: □ N: □	
Employer Name:	Occupation:		
Employer Address:	How long employed there	?	
City:State:Zip:			
How did you been shout us? (Institute automate a set of a con-			
now did you near about us? (include referral name, if applic	cable):		
	cable):		
DENTAL HISTORY	eable):		Yes: 🗆 No: 🗅
DENTAL HISTORY Your current dental health is: Good: Fair:	Poor: □ Do your gums e	ver bleed?	
How did you hear about us? (Include referral name, if applice DENTAL HISTORY Your current dental health is: Good: Do you like the color of your teeth? Yes: No: Do you feel like you	Poor: □ Do your gums e	ver bleed? your teeth?	Yes: 🗆 No: 🗅
DENTAL HISTORY Your current dental health is: Good: Fair: Do you like the color of your teeth? Yes: No: Do you feel like your afraid of needles? Yes: No: Do you feel like your seedles?	Poor: □ Do your gums e like the size and shape of y you have cavities at most o	ver bleed? your teeth? check-ups?	Yes: No:
DENTAL HISTORY Your current dental health is: Good: Fair: Do you like the color of your teeth? Yes: No: Do you feel like you afraid of needles? Yes: No: Do you feel like you have any dental fears?	Poor: Do your gums e like the size and shape of y you have cavities at most o	ver bleed? your teeth? check-ups?	Yes:
DENTAL HISTORY Your current dental health is: Good: □ Fair: □ Do you like the color of your teeth? Yes: □ No: □ Do you Are you afraid of needles? Yes: □ No: □ Do you feel like you have any dental fears? How can we make your dental visit more comfortable?	Poor: Do your gums elike the size and shape of you have cavities at most o	ver bleed? your teeth? check-ups?	Yes: No: Yes: No: Yes: No:
DENTAL HISTORY Your current dental health is: Good: Do you like the color of your teeth? Yes: No: Do you have any dental fears? How can we make your dental visit more comfortable? What would you change about your smile if you could?	Poor: Do your gums e like the size and shape of y you have cavities at most o	ver bleed? your teeth? check-ups?	Yes: No: Yes: No: Yes: No:
DENTAL HISTORY Your current dental health is: Good: Do you like the color of your teeth? Yes: No: Do you feel like you have any dental fears? How can we make your dental visit more comfortable? What would you change about your smile if you could? Why have you come to the dentist today?	Poor: Do your gums elike the size and shape of you have cavities at most o	ver bleed? your teeth? check-ups?	Yes: No: Yes: No: Yes: No:
DENTAL HISTORY Your current dental health is: Good: Do you like the color of your teeth? Yes: No: Do you feel like you have any dental fears?	Poor: Do your gums e like the size and shape of y you have cavities at most o	ver bleed? your teeth? check-ups? s dentist:	Yes: No: Yes: No: Yes: No:



EMERGENCY CONTACT/SPOUSE INFORMATION

His/Her Name:	Employer:
Date of Birth:SS#:	Work #: ()
Cell #: ()	
DENTAL INSURANCE INFORMATION	
Name of Employee:	Name of Employer:
Patient's Relationship to the employee:	Insurance Co. Name:
Employee's ID#:	Address:
Employee's DOB: Group#	Phone # for customer service: () -