

**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 \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security Num. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Email Address \_\_\_\_\_

**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? \_\_\_\_\_

\_\_\_\_\_

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