We Would Like to Get to Know You Better

Date___________

Full Name________________________________ Cell Phone(_____)______-_______ Home(_____)______-________

Home Address_____________________________Apt#_________ City________________ Zip_________ State_____

Email_____________________________ Date of Birth _____/_____/_______ Social Security#______-______-_______

Drivers License#___________ Marital Status________ Spouse's Name______________________

Occupation__________________ Employer_______________ Work Phone(_____)______-_______ Work Hours______

Emergency Contact____ Phone (_____)______-________

When was your last dental appointment?________________ Person responsible for dental investment_______________

How did you hear about us?_________________ Why did you leave your last dentist?____________________________

We Want to Take Care of Your Concerns and Needs First....

What are your present dental problems____

Do you avoid brushing any part of your mouth? ( )Yes ( )No

Do your Gums bleed when brushing? ( )Yes ( )No

Are your teeth sensitive to sweet, hot/cold or biting pressure? ( )Yes ( )No

I want to know about longer lasting solutions that may cost more ( )Yes ( )No

Does dental treatment make you nervous?
( )No ( )Slightly ( )Moderately ( )Very

I think my dental health is....
( )Excellent ( ) Good ( )Fair ( )Poor

If i could change my smile, I would make my teeth
( ) Whiter ( )Straighter ( )Close Spaces ( )Repair Chips

Other concerns/needs of mine are____

For Insurance Purposes....

Name of Policy Holder____________________________ Policy Holders Social Security#______________________

Policy Holder's Date of Birth____/_______/________ Employer__________________ Name of Ins Co.________________

Insurance Company's Phone#__________________Group#___________________ Ins Co Address_________________

Are you covered by another insurance plan, if so please complete the following....

Name of Policy Holder_____________________________ Policy Holders Social Security#_________________________

Policy Holder's Date of Birth_____/_______/_______ Employer________________ Name of Ins Co._________________

Insurance Company's Phone#(_____)______-_________ Group#_______________ Ins Co Address____________________