NAME ________________________________________DATE_________________________________________

ADDRESS_________________________________________________________

_________________________________________________________

PHONE # ______________________ CELL # ___________________________WORK #____________________

EMERGENCY CONTACT__________________________PHONE #______________________________________

EMAIL__________________________________

BIRTH DATE ________________________SEX __M__F

Social Security # _____ __ _____

OCCUPATION_____________________________________________________________________________

EMPLOYER/SCHOOL_______________________________________________________________________

ADDRESS_________________________________________________________________________________

DENTAL INSURANCE COMPANY_____________________________________________________

SUBSCRIBER'S NAME ____________________ BIRTHDATE_____________SS #__________________________

GROUP #______________________________

DO YOU HAVE SECONDARY INSURANCE? __Y__N

SUBSCRIBER'S NAME____________________BIRTHDATE_____________SS#___________________________

GROUP #______________________________

NAME OF PHYSICIAN_______________________________________________________________________

PHONE #______________________________

LIST ANY HEALTH PROBLEMS

LIST ANY ALLERGIES

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

ARE YOU TAKING BLOOD THINNERS? ___Y___N IF YES__________________________________________

DO YOU USE TOBACCO? __Y__N IF YES____________________________________________________

ARE YOU PREGNANT __Y__N DUE DATE__________________________________________________

Last Dental Visit _____________________

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

___________________________________________________________________________________________

HOW DID YOU HEAR ABOUT US? ______________________________________________________________

SIGNATURE OF PATIENT/PARENT/GUARDIAN

___________________________________________________________________________________________