



**About You**

Name \_\_\_\_\_  
                     First                    Middle                    Last  
 Preferred name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone: \_\_\_\_\_ home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_  
 Male \_\_\_\_\_ Female \_\_\_\_\_  
 Married\_\_ Unmarried\_\_ Separated\_\_  
 Birthdate \_\_\_\_\_ age \_\_\_\_\_  
 SS# \_\_\_\_\_ driver's lic# \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Spouse's name \_\_\_\_\_ occupation \_\_\_\_\_  
 Emergency contact \_\_\_\_\_ ph # \_\_\_\_\_

**Insurance**

Primary Insurance Company \_\_\_\_\_  
 Phone number \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Insured's Name \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Insured's Birthdate \_\_\_\_\_  
 Insured's Social Security # \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 If Secondary Insurance  
 (Give card to office manager)

We use email as our primary form of communication with patients.  
 We will never share your email with others.

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

In addition to email, would you like to receive confirmation texts? Yes or No

**General History**

What is your immediate dental concern?  
 \_\_\_\_\_

How did you hear about our office?  
 \_\_\_\_\_

Who was your previous dentist? \_\_\_\_\_

May we request your past records? \_\_\_\_\_

When was your last cleaning and exam? \_\_\_\_\_

Did you have x-rays taken at that time? \_\_\_\_\_

Are you nervous about going to the dentist?  
 \_\_\_\_\_

What can we do to make your visits more enjoyable?  
 \_\_\_\_\_

**Responsible Party for the Account**

(If different from the patient information)

Name \_\_\_\_\_  
 Relationship to pt \_\_\_\_\_  
 Birthdate \_\_\_\_\_  
 SS# \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Home# \_\_\_\_\_ work# \_\_\_\_\_