Welcome

"How can we make you smile today"?

Patient Information Today's date_____

Name(First, Last)_____Nickname_____DOB__ _____Gender_____

Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail _____Best Time to contact_____

Emergency Contact(s)_____Phone#_____ ____

Name of Responsible Party's Spouse_____ Age _____needs_____

Children (First, Last Name) _____Age_____needs_____

Children (First, Last Name) _____Age_____needs_____

Children (First, Last Name) _____Age_____needs_____

Other (First, Last Name) _____Age_____needs_____

Dental Insurance Company_____Insured Name_____

SS#_____ (need if you want us to file for Insurance)

Insured DOB_____Relationship to patient_____

Subscriber #_____Group#_____Employer_____

Are you interested in --? (Check all that apply)

Invisalign ☐ Children's Care ☐ All Ceramic Crowns ☐ Wire Braces ☐

Cosmetic Bonding ☐ Wisdom teeth ☐ Root Canals ☐ Permanent Dentures ☐

Veneers ☐ White Fillings ☐ Grafting Procedures ☐ Holistic Dentistry ☐

Dental Bridges ☐ Mild Sedation ☐ TMJ/Grinding ☐
Oral Cancer Screening ☐

Desensitizing Teeth ☐ Dental Implants ☐ Dentures/Partials ☐ Smile Whitening ☐

Full Dental Evaluation ☐ Oral CT scan ☐ Non-surgical Gum Treatment ☐
Removing Mercury Fillings ☐

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1. What concerns you most?

_____

2. Are you interested in preserving all of your teeth for your lifetime? ☐ or Have you given up on your teeth? ☐

3. How do you rate your smile 1-10? _____Why?