## Patient Information

Date________________________ ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐ Student ☐Child
Last Name________________________ First Name________________________ Middle________
Date of Birth________________ Social Security Number________________________
Address ________________________ City ________________________ State ________ Zip ________
E-Mail ________________________ Home #________________________
Work #________________________ Cell # ________________________
Employer ________________________ Phone # ________________________
If patient is a minor, give parents or guardian's name________________________
Name of nearest relative not living with you________________________
Complete Address________________________ Phone # ________________________
**Whom may we thank for referring you to our office?** ☐Patient ________________________
☐Mailing to Home (List Publication) ________________ ☐Location ☐Yellow Pages ☐Other________________

## Responsible Party Information

Last Name________________________ First Name________________________ Middle________
Date of Birth ________________ Social Security #________________ Relationship to Patient________________
Address ________________________ City ________________________ State ________ Zip ________
Home #________________ Work #________________ Cell # ________________
Previous Address (if less than 3 yrs.)________________________
Employer________________ Occupation ________________ No. Years Employed ________
Address________________________ Phone # ________________

**Spouse Information**

Last Name________________________ First Name________________________ Middle________
Date of Birth ________________ Social Security #________________ Relationship to Patient________________
Address ________________________ City ________________________ State ________ Zip ________
Home #________________ Work #________________ Cell # ________________
Employer________________ Occupation ________________ No. Years Employed ________
Address________________________ Phone # ________________

## Dental Insurance Information

| Primary Dental Insurance | Secondary Dental Insurance |
|---|---|
| Insured's Name________________ | Insured's Name________________ |
| Insured's Date of Birth________________ | Insured's Date of Birth________________ |
| Insured's Phone #________________ | Insured's Phone #________________ |
| Insured's Social Security #________________ | Insured's Social Security #________________ |
| Insurance Company ________________ | Insurance Company ________________ |
| Company Address ________________ | Company Address ________________ |
| ________________ | ________________ |
| Insurance Company Phone # ________________ | Insurance Company Phone # ________________ |
| Insured's Employer ________________ | Insured's Employer ________________ |

## Dental Information

Do your gums bleed when you brush? ☐ Yes ☐No
Are your teeth sensitive to heat or cold? ☐ Yes ☐No
Are your teeth sensitive to Pressure? ☐ Yes ☐No
Do you have a fear of the dentist? ☐ Yes ☐No
Do you grind or clench your teeth? ☐ Yes ☐No
Have you had your teeth bleached before? ☐ Yes ☐No
How do you feel about the appearance of your teeth? Do you: ☐Love them ☐Accept them ☐Want to change them
How do you feel about the appearance of your smile? Do you: ☐Love it ☐Accept it ☐Want to change it
Date of Last Examination ________________ What was done at that time?________________________
Are you interested in using Nitrous Oxide (Laughing Gas) ........................................ ☐Yes ☐No