

We Would Like to Get to Know You Better!

Date _____

Full Name _____ Phone (Hm) (____) _____ - _____ (Wk) (____) _____ - _____

Address _____ City _____ State _____ Zip _____

Email _____ Date of birth _____ Social Security # _____ - _____ - _____

Drivers License # _____ Marital status _____ Spouse's name _____

Occupation _____ Employer _____ Work Hours _____

Contact in case of emergency _____ Phone (____) _____ - _____

When was your last dental appointment? _____ Person responsible for your 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 sweets, hot/cold, or biting pressure? Yes No

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

Are you dissatisfied with your teeth and their appearance? 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 holder 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 plan? If so please complete the following...

Name of policy holder _____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth _____ Employer _____ Name of ins. co. _____

Insurance company's Phone _____ Group # _____ Ins. Co. Address _____