We Would Like to Get to Know You Better!

Date: _________

Full Name:____ Phone: [Hm] ________________ [Wk] _______________

Address: ____ City:________________ State:________ Zip:__________

E-mail: ____________________________________ Date of Birth:_________ Social Security #: _____________ _____

Drivers License #:____________________ Marital Status:________________ Spouse's Name:_____________________

Occupation:_________________________ Employer:__________________________ Work Hours:_________________

Contact in case of emergency:____ Phone: ____________________

When was our 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 Insurance 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 Insurance Co.______________________

Insurance company's Phone #:________________ Group #:_______ Ins. Co. Address:__________________________