WELCOME TO OUR OFFICE

WHO ARE WE SEEING TODAY?

Patient's Full Legal Name: ______________________ Date of Birth: __________

Mailing Address: ______________________
City: State: Zip:

Cell Phone Number: __________ Alternate Phone Number: __________

Email: ______________________ Social Security Number: __________

Who is your Dentist? __________ Dentist Phone Number: __________

RESPONSIBLE PARTY INFORMATION

Responsible Party Full Name: ______________________

Your Phone Number: __________ Secondary Phone Number: __________

Mailing Address: ______________________
City: State: Zip:

Email: ______________________ Date of Birth: __________

How would you prefer to be contacted? Phone Call, Text, or Email? __________

Relationship to Patient: __________ Social Security: __________

Would you like to get braces today? __________ How did you find out about us? __________

INSURANCE INFORMATION

Insured's Name: __________ Date of Birth: __________ Social Security: __________

Employer Name: __________ Insurance Company: __________

Group Number: __________ Policy Number: __________ Effective Date: __________

Relationship to Subscriber: __________ Phone Number: __________

Insurance Company Address: ______________________

SECONDARY INSURANCE INFORMATION

Insured's Name: ____________________ Date of Birth: ____________ Social Security: ____________

Employer Name: ______________________________ Insurance Company: ________________

Group Number: ____________ Policy Number: ____________ Effective Date: ____________

Relationship to Subscriber: ____________________ Phone Number: ____________________

Insurance Company Address: ____

EMERGENCY INFORMATION

Emergency Contact Person: ____

Relationship to Patient: ______________________________ Phone Number: ________________

Email Address: ____

Please Circle Yes or No to the Following Questions:

Have seen a dentist in the last six months? ○ yes ○ no

Do you have cavities or gum problems that need treatment or have been treated? ○ yes ○ no

If so, please explain:____

Have you had any injuries to the teeth, jaws, or head? ○ yes ○ no

If so, please explain:____

Do you see a physician? ○ yes ○ no

Do you have a medical, psychiatric, physical or other health condition that required past or ongoing medical doctor visits and/or treatment? ○ yes ○ no

If so, please explain:____

Do you have any history of bleeding problems? ○ yes ○ no

If so, please explain:____

Do you take any prescription or over-the-counter medications? ○ yes ○ no

If so, please explain:____

Do you have any allergies to medication, food, or environmental substances? ○ yes ○ no

If so, please explain:____

Are you pregnant or is there a chance you are pregnant? ○ yes ○ no

I certify this information is true and correct to the best of my knowledge. I understand that I am responsible for all financial charges.

Name: ______________________________ Date: ____________________