WELCOME TO OUR OFFICE

WHO ARE WE SEEING TODAY?

How did you hear about our office? Dentist Friend_____ Google Instagram Facebook Insurance

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: _____

How would you prefer to be contacted? Phone Call, Text, or Email? _____ Would you like to get braces today? _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Full Name: _____

Phone Number: _____

Mailing Address: _____
City: State: Zip:

Email: _____ Date of Birth: _____

Relationship to Patient: _____ **Social Security:** _____

POLICY HOLDER INSURANCE INFORMATION

Policy Holder's Name: _____ Date of Birth: _____ **Social Security:** _____

Employer Name: _____ Insurance Company: _____

Group Number: _____ Policy Holder ID: _____ Effective Date: _____

Relationship to Patient: _____ Insurance Phone Number: _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____ Date of Birth: _____ **Social Security:** _____

Employer Name: _____ Insurance Company: _____

Group Number: _____ Policy Holder ID: _____ Effective Date: _____

Relationship to Patient: _____ Insurance Phone Number: _____

EMERGENCY INFORMATION

Emergency Contact Person: _____

Relationship to Patient: _____ Phone Number: _____

Please Circle Any Medical Conditions That May Apply to the Patient:

ADD or ADHD
AIDS
Anemia
Arthritis
Artificial Bones or Joints, or Values
Autism
Asthma
Blood Disorders
Brain Injury
Cancer
Cancer Medication
Diabetes
Dizziness or Fainting
Drug or Alcohol
Emphysema
Epilepsy
Frequent Colds
Frequently Tired
Glaucoma
Handicap or Disabilities
Hearing Impairment
Heart Attack
Heart Congenital Defect
High Blood Pressure
Kidney Disease
Liver Disease
Heart Murmur
Heart Surgery/Pace Maker
Heart Trouble
Hemophilia/Abnormal Bleeding
Hepatitis or Jaundice
Herpes
Low Blood Pressure
Mitral Valve Prolapse
Periodontal Disease
Psychiatric Problem
Respiratory Problems
Rheumatic Fever
Seizures
Shingles
Sickle Cell Disease
Stomach Ulcers
Stroke
Thyroid Problem
Tuberculosis
Other

Please Circle Any of the Habits That May Apply to Patient:

Abnormal Breathing
Nail Biting
Tongue Sucking
Grinding Teeth
Smoking
Tongue Biting
Mouth Breathing
Thumb Sucking
Tobacco in any Form

Please list any Medications Patient Takes (over the counter and prescription): _____

_____

Please list any Patient Allergies (latex, metal, medications, etc.): _____

_____

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: _____