Patient Information

Date:_____

Title & Name:_____ Preferred Name: _____

DOB: _____ Marital Status: _____ Sex: _____

Address: _____ City, State, Zip: _____

Home Ph:_____ Work Ph: _____ Cell: _____

E-mail:_____ Best Way/Number to Reach You:_____

SSN:_____ Emergency Contact:_____ Ph: _____

Preferred Pharmacy & Location (City):_____ Ph:_____

Employer:_____ Occupation:_____

Whom May We Thank For Referring You To Our Office?_____

Members of Family Being Treated in our Office:_____

INSURANCE: Please complete so we may assist you in receiving your insurance benefits

Insurance Policy Holder:_____ Policy Holder DOB: ____/____/_____ ID/SSN:_____

Employer:_____ Insurance Company:_____ Group #:_____

Claims Mailing Address:_____ Eligibility #:_____

Dental History

Chief Concern for Today's Visit: _____

When Was Your Most Recent Dental Visit?: _____ Dentist Name & Specialty:_____

Were X-Rays Taken?:_____ Were You Covered Under The Same Dental Insurance During That Visit?_____

How Would You Describe Your Dental Health? (Please Check One):_____ Excellent _____ Good _____ Fair _____ Poor

What rating would you give your teeth on a scale of 1 – 10? (1 being poor and 10 being excellent) _____

What priority would you give your teeth on a scale of 1 – 10? (1 being low and 10 being high) _____

Do You Gag Easily During: (Please Check All That Apply) _____ X-Rays _____ Impressions _____ Procedures _____ Other: _____

Do You Have Any Of The Following?: (Please Check All That Apply) ___ Sensitive Teeth ___ Bleeding Gums ___ Clenching and/or Grinding

___ Dry Mouth ___ Pain and/or Discomfort in Your Mouth ___ Biting of Cheeks ___ Unpleasant Taste or Odor ____ Loose Teeth

Has Your Smile Changed in the Last Five Years?: ____ Yes ____ No; if 'Yes', Please Describe: _____

_____

Is There Anything You Would Change About Your Smile? (Please Describe)_____

_____

Do You Wish To Speak With The Doctor Privately About Any Cares or Concerns? _____ Yes _____ No

I will allow Promenade Complete Dental Center, LLC to discuss my condition(s) with my physician and/or other treating providers via email or other means and to request information from them as necessary. _____ (initial)

I will allow Promenade Complete Dental Center, LLC to photograph and use for educational and marketing purposes, via email or other means, any aspects of my dental condition(s) or treatment procedures. _____ (initial)

Signature Date