Mr. Mrs . Ms. Dr Legal Name:

(Preferred Name) Date of Birth:

Addresss:

Home Phone Cell Phone Email:

Dental Insurance: Yes No

Insurance Company Name: Mailing Address:

Phone: Group/Plan Number:

Are you the subscriber: Yes No (if no subscriber name): Subscriber Date of Birth

Your Member ID#: SSN#:

Drivers License/ID #: State of Issue:

PRELIMINARY MEDICAL/DENTAL HISTORY

Do you have any Major Medical Conditions?(high blood pressure, diabetes…) Yes No

Is there any chance you can be pregnant? Yes No

Have you ever been treated for Periodontal Gum disease? Yes No

Is someone accompanying you? Yes No Name and Relation:

What is your main dental concern today?

How is your current dental condition affecting you (Ex: pain, difficulty eating, difficulty talking)?

How would treating your dental condition change your life?

How soon would you like to start your dental treatment?

We may need to contact you from time to time related to your treatment. Best way to contact you reg regarding messages, responses, test results, etc:

May we leave a message on home/cell voicemail? Yes No

May we contact you via Email? Yes No

May we contact you via text message? Yes No

(Standard text or data usage rates may apply depending on your plan and/or carrier)

My medical care may be discussed with: Name: Relationship

I do not want my treatment to be discussed with any other person.

I, have been informed that I will receive treatment from multiple specialists. I agree my records shall be with any designated specialist providing dental treatment.

I certify that I speak, read, and write English, have read, and fully understand this form, and that all blanks were filled in prior to signing this form.

Signature:_____

Date:_____

Witness Signature:_____

Date:_____

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