## WELLCOME

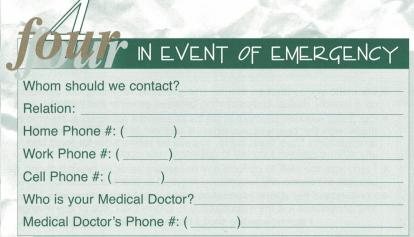


## ABOUT YOU

Today's Date:			File #:	
Patient Name:		FIRST	MI	
What You Prefer To Be	e Called:			
Birthdate://	Age:_	SS#:		
Mailing Address:				
CITY		STATE	ZIP	
Home Phone #: (	)			
Work Phone #: (	)		Ext:	
Cell Phone #: (	_)			
E-mail Address:				
Referred By:				
Employer:	yer:How Long?			
Employer's Address:_				
CITY		STATE	ZIP	
Occupation:	*			
Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed				
Spouse's Name:				
Do you have children?	□ Yes □ N	lo How ma	any?	



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tryo	N5URANCE	INF0
Primary Dental Insurance		
Co. Name:		
Address:	:	
CITY	STATE	ZIP
Phone #: ()		
Insured's ID#:		
Group # (Plan, Local, or Policy	/ #):	<u> </u>
Insured's Name:		
Relation:	Date of Birth:/	
Insured's Employer:		
Secondary Dental Insuran	ce	
Co. Name:		
Address:		
CITY	STATE	ZIP
Phone #: ()		
Insured's ID#:		
Group # (Plan, Local, or Policy	#):	
Insured's Name:		
Relation:	Date of Birth:/	/
Insured's Employer:		



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	DENTAL INFORMATION				
Reason for today's visit:  Exam  En En Exam  En Exam  En Exam  Exa					
Please indicate a any of the following proble Discomfort, clicking or popping in jaw.					
☐ Red, swollen or bleeding gums. ☐ ☐ Sensitive tooth, teeth or gums. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Teeth grinding ☐ Locking Jaw Ringing in Ears ☐ Bad breath				
☐ Other: Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know					
Previous Dentist:  Name  Last Dental exam: / / Last	()Phone#				
Times a day you brush? Times a What type of tooth brush bristles do you use	a week you floss?				
How would you rate your smile? (Worst) 1 2	3 4 5 6 7 8 9 1 0 (Best)				



	Please rate your general health from 1-10: Do you wear contact lenses? \(\simeg \) Yo For women: Are you taking Birth Control pills? \(\simeg \) Yes \(\simeg \) No How many children have you have			
	Are you Pregnant? ☐ No ☐ Yes/How long? Are you nursing? ☐ Yes ☐ No			
	e you to discuss with us any questions regarding our services. The best Dental health services are based andly, mutual understanding between provider and patient.	UPDATE (OFFICE USE)		
<ul> <li>Our police made with arrangen any othe</li> </ul>	/ / / Initials Date			
any other expenses incurred in collecting your account.  I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.				
	and the above information and guarantee this form was completed correctly to the best of my knowledge erstand it is my responsibility to inform this office of any changes to the information I have provided.  I acknowledge that I have received a copy of the Summary of Privacy Notice.	Comments  / / / Initials Date		
Initials	Signature Date/	Comments		
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