

DENTAL INFORMATION

Do your gums bleed when you brush or floss? __ Yes __ No
 Have your gums receded? __ Yes __ No
 Have you noticed any loose teeth? __ Yes __ No
 Have you had any periodontal (gum) surgery? __ Yes __ No
 Would you say that you have had a __ Minimal __ Moderate or __ Major
 Amount of previous dental treatment?
 Would you guess that you need a __ Minimal __ Moderate or __ Major
 Amount of treatment now?
 Would you say that you have a __ Low __ Moderate __ High
 Susceptibility to cavities?
 Do you have any crowns (caps) or bridgework? __ Yes __ No
 About how many? _____
 Have you ever had any braces or retainers? __ Yes __ No
 Have you had any permanent teeth extracted (other than
 wisdom teeth)? About how many? _____ __ Yes __ No
 Please describe any other dental information that you feel may be important to us:

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Complete this section if someone other than the patient is responsible for payment

Responsible Person's Full Name: _____
 Address: _____
 Relationship to Patient: _____ Home Phone: _____ Work Phone: _____
 Employer: _____ How Long? _____ Occupation: _____
 Date of Birth: _____ S.S. Number: _____ Marital Status: _____

INSURANCE INFORMATION

We do not accept assignment of insurance but we will be happy to complete the forms and process the payment to you directly.

Patient's Relationship to Insured Employee _____
 Full Name of Insured Employee _____
 Date of Birth S.S. Number Marital Status
 Home Address _____
 City State Zip
 Home Phone Work Phone
 Employer Insurance Company Group Number