Welcome
TO THE DENTIST

Please fill out this form completely, it is important to your dental care.
Our goal is to help you reach and maintain good oral health.

1 About You

Today's Date: ____________

Name: ____________ LAST ____________ FIRST ____ MI ☐ M ☐ F

Birthdate: ___/___/___ Age: ____ SS#: ____________

Home Address: ____________

____________ CITY ____ STATE ____ ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____) ____________ Cell #: (____) ____________

Wk #: (____) ____________ DL #: ____________

E-Mail Address: ____________

Employer: ____________

Employer's Address: ____________

____________ CITY ____ STATE ____ ZIP

How long there? ____________ Occupation: ____________

When is the best time to reach you? ____________

Whom may we thank for referring you? ____________

Other family members seen by us: ____________

General Dentist: ____________

Previous or Present (Please circle) Date of last visit: ____________

2 Spouse Information

His/Her Name: ____________

Employer: ____________

Wk #: (____) ____________ Ext: ____

Birthdate: ___/___/___ SS #: ____________

Person Responsible for Account: ____________

Wk #: (____) ____________ Hm #: (____) ____________

Billing Address: ____________

Relation: ____________ SS #: ____________

Employer: ____________ DL #: ____________

In the event of an emergency, whom should we contact?

His/Her Name: ____________

Relationship: ____________

Wk #: (____) ____________ Hm #: (____) ____________

3 Insurance Information

PRIMARY

Dental Coverage: ☐ Y ☐ N

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

SECONDARY

Dental Coverage: ☐ Y ☐ N

Insurance Co. Name: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

4 Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: ____________

Ph #: (____) ____________ Date of last visit: ____________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: ____________

Are you taking any prescriptions, over-the-counter drugs or herbal supplements? ☐ Y ☐ N

Please list: ____________

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Have you ever taken Phen-Fen? ☐ Y ☐ N

Have you ever taken Fosamax or any other bisphosphonate? ☐ Y ☐ N

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Continued on back