LIFE LONG DENTAL CARE

Patient Information

Name: Soc. Sec. #:

Last Name First Name Middle Initial

Address: Town: Zip:

Birthday: Age: Gender: Marital Status:

Mobile Phone: Home Phone:

Work Phone: May we text you appointment updates?

Email Address: May we send you reminders via Email?

Referred by: Are you a current patient?

Emergency Contact Name: Phone Number:

Primary Dental Insurance

Name of Subscriber:

Relation to Patient: Birth Date: Soc.Sec. #:

Address (if different from patient): Zip:

Employer Name: Occupation:

Business Address: Zip:

Business Phone: Names of dependents on plan:

Insurance Name: Group #: Subscriber #:

Secondary Dental Insurance

Name of Subscriber:

Relation to Patient: Birth Date: Soc.Sec. #:

Address (if different from patient): Zip:

Employer Name: Occupation:

Business Address: Zip:

Business Phone: Names of dependents on plan:

Insurance Name: Group #: Subscriber #:

Dental History

Reason for Todays visit:

Current or Former Dentist:

Address: Zip:

Date of last dental Care: Date of last X-rays:

Check (x) if you have had problems with any of the following:

_____ Bad Breath	_____ Food collection between teeth	_____ Sensitivity to heat
_____ Bleeding Gums	_____ Loose teeth or broken fillings	_____ Sensitivity to sweets
_____ Clicking/ popping jaw	_____ Periodontal Treatment	_____ Sensitivity when biting
_____ Grinding Teeth	_____ Sensitivity to cold	_____ Sores or growths in your mouth

How often do you floss? How often do you brush?