

# Welcome

to our office



*"Sedation - Dental Care while you "Sleep"*

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

### Patient Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

I like to be called: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's S.S.#: \_\_\_\_\_

Home address: \_\_\_\_\_  
Street City Zip

Email address: \_\_\_\_\_

Marital status:  Single  Married  Divorced  Widowed Home Ph # \_\_\_\_\_ Cell Ph # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Ph # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Whom can we thank for referring you? \_\_\_\_\_

In case of emergency, is there someone we can call? Name \_\_\_\_\_ Ph # \_\_\_\_\_

### Responsible Party Information

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ S.S. # \_\_\_\_\_

Home Address \_\_\_\_\_

Home Ph # \_\_\_\_\_ Work Ph \_\_\_\_\_

Employer \_\_\_\_\_

Name of spouse \_\_\_\_\_

### Insurance Information

Are you covered under a dental insurance policy or plan?

Yes  No

If so, please give us your dental insurance card to copy for our records and a completed insurance form with employee's signature.

### Medical History

Name of Personal physician \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last visit with physician \_\_\_\_\_ Current health:  Excellent  Good  Fair

Do you smoke or use chewing tobacco?  Yes  No If yes, how much per day? \_\_\_\_\_

Are you currently taking prescription medications?  Yes  No If yes, list below:

Name of medication	Purpose

*"We Care for People Not Just Teeth"*

