

Confidential Patient Information

Date _____

PATIENT: Name _____
(Last) (First) (Middle)

Home Phone _____

Address _____
(City) (State) (Zip)

Place of Employment _____ Occupation _____

Business Address _____ Business Phone _____

Date of Birth _____ SS# _____ Male Female

Marital Status Single Married Divorced Widowed

SPOUSE: Name _____
(Last) (First) (Middle)

Place of Employment _____ Occupation _____

Business Address _____ Business Phone _____

Person Responsible for Account _____ Whom may we thank for referring you to our office? _____

Has any member of your family been treated in our office previously? Yes No Relationship _____

Why did you choose Dr. Hickey as your dentist? _____

Reason for visit _____

DENTAL HEALTH Please check one: Excellent Good Fair Poor

Are you happy with the color of your teeth? Yes No

Are you pleased with your smile? Yes No If not, explain _____

What priority do you give your teeth(10 being the highest)? 1 2 3 4 5 6 7 8 9 10

INSURANCE: Please complete the following confidential information regarding Dental Insurance

Primary Carrier Insurance Company: _____

Mailing Address _____

Employee: _____ SS# _____ Group # _____

Secondary Carrier Insurance Company _____

Mailing Address _____

Employee: _____ SS# _____ Group # _____

MEDICAL HEALTH: Please check one: Excellent Good Fair Poor

Physician's Name _____

Last complete physical? _____ Are you under a doctor's care now Yes No If yes, for what reason _____

Have you ever received a blood transfusion? Yes No When? _____

Are you subject to fainting spells? Yes No Are you pregnant? Yes No If yes, how long _____

****Over****

