PATIENT HISTORY DATE: ____________

Patient's Name: ___________________________ Name you prefer to be called: _______________ DOB: ________

Address: ______________________ City: ___________ State: ___ Zip: _______Home Phone: ________________

Work Phone: _______________Cell Phone: _______________ E-mail: _____________________ S.S. #: __________

Best Number and Time to Reach You: _________________ Place of Employment: ______________________________

Occupation: ___________________________ Business Address: ____

Spouse: Name: _____________________________ Work: __________Emergency Contact Name: ________________

Phone: ______________________ Members of family being treated in our office: _______________________________

Whom may we thank for referring you to our office? : ____

INSURANCE: Please complete so we may assist you in receiving your insurance benefits

Employee: ______________________________ Relationship to Insured: __________________________________

DOB of Employee: _____________________ S.S. # ______________________ Employer: ______________________

Primary Carrier: ____________________________ Claim Mailing Address: _________________________

Carrier Phone Number: ________________________ Group # ________ ID # _________________________

DENTAL HEALTH: Please check one: ____Excellent ____Good ____Fair ____Poor

What priority do you give your teeth (10 being the highest)? ________

What would you change about your smile? ____

____

Do you have? ___Sensitive Teeth ___ Bleeding Gums ____ Awareness of Clenching ___Pain/Discomfort in your mouth?

Do you wish to talk to a doctor privately about any problem? ____Yes ____ No

I will allow Haymarket Dental-Complete Care to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow her permission to discuss my conditions with my physician and to request information from him.

____

Patient, or Parent or Legal Guardian signature Date