Welcome to our Practice

Today's Date _____

Patient's Name _____ **Gender** _____

Birth Date ____ /_____ /_____ **Age** _____ **Marital Status** _____

SS# --_____ **Driver's License** _____

Address _____
Street City State Zip

Phone --_____ --_____ --_____
Home Work Cell

Which is the best number to reach you at M – F between 8 – 5pm? _____

Your Employer _____

Employer's Address & Phone --_____

Spouse's Name _____ **Spouse's Employer** _____

Emergency Contact --_____
Name Phone

Billing Information

Person responsible for account (if different than the patient)

_____ _____
Name Relation to the Patient

_____
Address Home # Work # Cell #

SS # _____ **Driver's License #** _____ **Birth Date** _____

Employer _____

Employer's Address & Phone _____

How did you hear about our office? _____

Smile Evaluation

Name _____

Please let us know what you think about your smile by using our grading system.

A = Love It
B = Acceptable
C = Could Be Better
D = Don't Like It
E = Don't Like It At All
NP = Not A Problem

_____ **Whiteness**

_____ **Staining/Discoloration**

_____ **Alignment of Teeth**

_____ **Chipping/Cracking**

_____ **Existing Dental Work**

_____ **Gum Health/Appearance**

_____ **Smile Line (Do you see too much or not enough of your smile?)**

Is there any thing else we should know about your smile?

Today's Date _____