PATIENT INFORMATION

Please complete both sides of form

Date: _____

Last Name: _____ First Name: _____ M.I. _____

Mailing Address: _____ Apt#: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: ◯ ◯ ◯ ◯

Employer: _____ Job Title: _____

Department: _____ Social Security # _____

Home Phone: _____ Work Phone: _____ EXT _____ Cell Phone: _____

if the patient is over Age 18 and is a full time student, please list the name and address of the school:

_____

Nearest Relative or Emergency Contact (Not Living With You): _____ Phone # _____

Accompanying Parent/Guardian/Power of Attorney

Name: _____ Social Security # _____

Address: _____

Employer: _____

Home Phone: _____ Work Phone: _____ EXT _____ Cell Phone: _____

Date of Birth: _____ Relationship to Patient: _____

Please answer the following questions for our records and for your safety:

Do now have, or have you ever had, TMJ problems (Clicking, locking, pain in jaw joint? ☐ Yes ☐ No

Did your doctor send an X-Ray to us? ☐ Yes ☐ No

Did you bring an X-Ray with you? ☐ Yes ☐ No

Have you had an X-Ray taken in the last 3 years? If so, where? _____

Referral Information

You were directly referred by Doctor: _____ Other: _____

Your Dentist and/or Periodontist is: _____

Your Orthodontist is: _____

_____