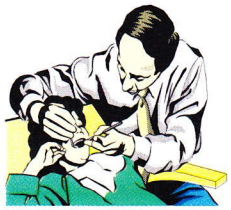

GENERAL PATIENT INFORMATION

NAME _____ TODAY'S DATE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

HOME ADDRESS _____

CITY and STATE _____ _____ ZIP _____

HOME PHONE NUMBER _____ Cell Phone _____

OCCUPATION _____

BUSINESS NAME _____

BUSINESS ADDRESS _____

BUSINESS PHONE NUMBER _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DENTAL HEALTH

1) DO YOU HAVE A DENTAL PROBLEM AT THIS TIME? _____

2) WHEN WAS YOUR LAST FULL MOUTH SERIES OF X-RAYS? _____

3) DO YOU TAKE DENTAL ANESTHESIA (INJECTION) FOR DENTAL WORK? _____

4) DID YOU EVER HAVE A BAD REACTION TO DENTAL ANESTHESIA? _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? _____ GROUP # _____
NAME and ADDRESS OF INSURANCE COMPANY _____

_____

NAME OF SUBSCRIBER _____
SUBSCRIBER'S EMPLOYER _____
DATE OF BIRTH _____ PATIENT'S RELATIONSHIP TO SUBSCRIBER _____
SOCIAL SECURITY # OR INSURANCE ID # _____