



Please edit any incorrect information and fill out all of the blanks below.

Chart: _____

Patient Information

Patient Name: _____
Nickname: _____ Date of Birth: _____
Social Security number: _____ Gender: _____
Address: _____
Home Phone: _____ Work Phone: _____
Mobile Phone: _____ Email address: _____
How would you like us to contact you during the day? (circle one) Home Cell Work Email

General Information

Who can we thank for your referral? _____
What don't you like about your smile? _____
What are the patient's hobbies/interests? _____

Dentist/Physician information

Dentist Name: _____ Dentist Phone: _____
Last cleaning date: _____
Physician Name: _____ Physician Phone: _____
Is the patient currently under the care of a physician? Yes No
If yes, please explain _____

Parent Information (If patient is a minor) and Insurance Information

Father's Name: _____ Social Security number: _____
Address _____ Date of Birth: _____
City, State, Zip code: _____ Home phone: _____
Employer: _____ Work phone: _____
Insurance company: _____ Mobile phone: _____
Insurance address: _____ Insurance phone number _____
Insurance city, state, zip _____ Insurance group number _____
Spouse's Name: _____

Mother's Name _____ Social Security number _____
Address _____ Date of Birth _____
City, State, Zip code: _____ Home phone: _____
Employer: _____ Work phone: _____
Insurance company: _____ Mobile phone: _____
Insurance address: _____ Insurance phone number _____
Insurance city, state, zip _____ Insurance group number _____
Spouse's Name: _____

Siblings' Names and Ages:

Parent/Guardian name: _____ Date: _____
Signature: _____
Relationship to patient: _____