

Patient _____ Date of Birth _____
(Mr.,Mrs.,Ms.,Dr.) Last First

How do you wish to be addressed? _____ Marital status: _____

Name of Parent or Spouse: _____

Local home address: _____ Home# _____

Are you a seasonal resident? _____ If so what months are you here? _____

Seasonal address: _____ Phone# _____

Social security # _____ E-mail address: _____

Occupation: _____

Work # _____

How long there? _____

Reason for your visit today?

Whom may we thank for this referral? _____

Do you have children? _____ Grandchildren? _____

What are your hobbies?

Former Dentist: _____ Phone # _____

Do you have current x-rays that you would like us to have forwarded? _____

What did you like or dislike about your previous dentist? _____

What bothers you most about going to the dentist? _____

Is there anything we can do to make your visit more enjoyable? _____

Person responsible for account: _____ Do you have dental insurance ? _____

Payment is expected as services are rendered. We accept Master Card, Visa and Discover.

Financing is available depending on circumstances.

We do not accept assignment of dental benefits. We will gladly process your claims for you after payment in full has been made.

Your signature below indicates that all the above information is correct to the best of your knowledge and that you understand our financial policy. Thank-you for your assistance.

Signature: _____ Date _____