Person & Darlington
Family and Cosmetic Dentistry

Patient Information

Date____

Name____

Address____

City_______________________ZIP__________________

State____

Email____

Sex____

Birthdate____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

SSN____

Occupation____

Employer/School____

Employer/School Phone___________________________________

Employer/School Address_________________________________

Whom may we thank for referring you?

____

Dental Insurance Information

Who is responsible for this account?____________________

Relationship to Patient______________________________

Insurance Co.______________________________________

Group #____

Is the patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name__________________________________

Birthdate____________________SSN_________________

Relationship to Patient______________________________

Insurance Co.______________________________________

Group #____

I certify that I, and/or my dependent(s), have insurance coverage and the information listed above is accurate.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________________ ____________________
Date Relationship to patient

Phone Numbers

Cell Phone___________________________________ Work Phone__________________Ext_____

Spouse's Cell Phone__________________________ Spouse's Work Phone_______________

Best time to reach you____________________________

EMERGENCY CONTACT (Preferably someone not in the same household)

Name_____________________________________Relationship_____________________________________

Cell Phone_________________________________ WorkPhone_____________________________________

Dental History

Reason for today's visit_______________

____

Previous Dentist (if applicable)

____

City/State__________________________

Date of last dental visit_______________

Date of last dental x-rays______________

How often do you brush?______________

How often do you floss?_______________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Blisters on lips or mouth
☐ Burning on tongue
☐ Chew on one side of mouth
☐ Cigarette, pipe, or cigar
☐ Smoking
☐ Dry mouth
☐ Fingernail biting
☐ Food collection between teeth
☐ Foreign objects
☐ Grinding teeth
☐ Swollen gums
☐ Jaw pain/tiredness
☐ Lip/Cheek biting
☐ Loose teeth/Broken fillings
☐ Mouth breathing
☐ Mouth pain/bruising
☐ Orthodontic treatment
☐ Periodontal treatment
☐ Pain around ear
☐ Sensitivity to:
☐ Hot ☐ Cold ☐ Sweets ☐ Chewing