1 PATIENT INFORMATION

Patient Name: ______________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security #: ______________________

Birth Date: ______________________

Home #: ____________ Work #: ____________

Cell #: ______________________

E-Mail Address: ______________________

Address ______________________
Street Apt. #

____
City Zip Code

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse
☐ the person responsible for payment

Name: ______________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single

Social Security #: ______________________

Birth Date: ______________________

Home #: ____________ Work #: ____________

Address ______________________
Street Apt. #

____
City Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient
☐ the person responsible for payment

Employer Name: ______________________

Occupation: ______________________

Address ______________________
Street Apt. #

____
City Zip Code

IN CASE OF EMERGENCY

Name ______________________

Home (____)____________ Work (____)____________

Relationship ______________________

Cell Phone (____)____________

2 INSURANCE INFORMATION

Subscriber's Name: ______________________

Subscriber's Birth Date: ______________________

Subscriber's SS#: ______________________

Relationship to Patient: ______________________

Insurance Co.: ______________________

Group #: ______________________

Is there any additional dental insurance? ☐ Yes ☐ No

Subscriber's Name: ______________________

Subscriber's Birth Date: ______________________

Subscriber's SS#: ______________________

Relationship to Patient: ______________________

Employer: ______________________

Insurance Co.: ______________________

Group #: ______________________

3 REFERRAL INFORMATION

Whom may we thank for referring you to Shandrick Dental Care?

☐ Passing By ☐ Yellow Pages
☐ Another Patient ☐ Friend
☐ Work ☐ Other ____________
☐ Relative ☐ Other ____________

____
Name of Person Referring you to us:

4 DENTAL INTERVIEW D I S C

Name of Previous Dentist
and Location ______________________

How long has it been since
Your last *thorough exam*? ______________________

How long has it been since your last
complete series / full mouth x-rays
of your teeth? ______________________

What prompted you to seek
dental care at this time? ______________________

At what point do you want to initiate treatment? (circle one)
a. When my tooth hurts or breaks.
b. When something is worsening
c. When something isn't ideal

What quality of dentistry do you want us to
recommend? (circle one)
a. "Just Patch It"
b. Average
c. Ideal / The Best