socalsmiles
Dental Office
18399 Ventura Blvd., Suite 251 • Tarzana, CA 91356

Patient Information

Date_____ Patient's Name _____
Last First Middle
Address _____
Street Unit# City State Zip
Home Ph. # (____)_____ Work Ph. # (____)_____ Cell Ph. # (____)_____Marital Status _____

Soc. Sec. #_____ - _____ - _____ Drivers Lic. # _____ E-mail: _____

Birthdate ____ / ____ / _____ Sex M F If patient is a minor, give parent's/guardian's name_____

If patient is a full-time student, fill in school name _____

Emergency Contact _____ Ph. # (____) _____

Who may we thank for referring you_____

Responsible Party Information

Name_____
Last First Middle
Soc. Sec. #_____-_____-_____ Birthdate _____ / _____ / _____ Relationship to Patient _____

Residence _____
Street Apt# City State Zip
Mailing Address _____
Street Apt# City State Zip
How long at this address _____ Home Ph.# (_____) _____ Work Ph.# (_____) _____ Fax# (_____) _____

Previous Address (if less then 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address_____

Spouse's Name _____

Soc. Sec.# _____ - _____ - _____ Birthdate _____ / _____ / _____ Work Ph. # (_____) _____ Fax# (_____) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Dental Insurance Information

Insured's name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address_____ Ph.# (_____) _____

Insured's Employer _____ Ph.# (_____) _____

Do you have dual coverage? Yes___ NO ___ If yes: **Please complete the following secondary insurance information.**

Insured's name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address_____ Ph.# (_____) _____

Insured's Employer _____ Ph.# (_____) _____

Dental Information

Do your gums bleed when you brush? Yes ____ No ____

Are your teeth sensitive to heat or cold? Yes ____ No ____ Pressure Yes ____ No ____ Sweets Yes ____ No ____

Do you grind or clench your teeth? Yes ____ No ____

Do you have any fear of dental work? Yes ____ No ____

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

_____

How do you feel about appearance of your teeth? _____