Saxon Dental

Welcome to Saxon Dental. All information on this chart is necessary for our records.

Patient Information

First Name _____ Last name_____ MI_____

Address _____ City/State/Zip_____

Home Phone _____ Work_____ Cell_____

Birth Date_____ Age_____ Soc Sec #_____ Dr. Lic #_____

Email _____ □ I would like to receive correspondence via e-mail

Employment Status: □ Full Time □ Part time □ Retired Employer_____

Student Status: □ Full time □ Part time School Name_____

Emergency Contact _____ Relationship_____ Phone_____

Please let us know how you heard about Saxon Dental: □ Friend/ Relative_____
□Insurance_____ □ Yellow Pages □ Signage □ Advertising □ Other_____

Insurance Information

Name of Insured_____ Insured Soc Sec #_____

Insured Birth Date_____ Relationship to Insured: □ Self □ Spouse □ Child □ Other

Employer _____ Phone # :_____

Insurance Company:_____ Phone Number:_____

Policy #_____ Group #_____

Responsible Party Information For Minors

Person Responsible for Payment_____ Date of Birth_____

Phone Number:_____ Work Number:_____ Cell Number_____

Soc Sec # of Person Responsible_____ Dr. Lic #_____

Employers Name_____

Are you having any of the following?

Discomfort □Yes □No
Sensitivity □Yes □No
Throbbing Pain □Yes □No

If you could change your smile you would:

Whitten Teeth □Yes □No
Close Spaces □Yes □No
Change silver fillings to white □Yes □No

Have you experienced any of the following problems?

Snoring □ Yes □No Bad Breath □Yes □ No
Bleeding gums □Yes □No Grinding □Yes □No
Uncontrolled hand movement □Yes □No
Teeth turning yellow □Yes □No
Difficulty reaching back teeth □Yes □No

Denture and Partial Patients:

How old is your denture/partial?_____
Have your relined your dentures before? □Yes □No
Are your dentures/partial loose? □Yes □No
Do you use any denture adhesive? □Yes □No