PATIENT INFORMATION

(Please print in ink)

Name _____ **Preferred Name/Nickname** _____

Date of Birth _____ **Social Security Number** _____

Address _____ **City**_____ **Zip** _____

CONTACT INFORMATION (*Please circle one if preferred*):

Home Phone _____ **Cell Phone** _____

Work Phone _____ **Email Address** _____

Employer _____ **Occupation** _____

Employer Address _____ **City**_____ **Zip** _____

Marital Status _____ **Spouse's Name** _____

Emergency Contact _____ **Phone** _____

Is there a person(s) with which you give us permission to discuss your Dental/Medical Treatment/History?

Name _____ **Phone** _____

DENTAL INSURANCE INFORMATION

	Primary Insurance Company	Secondary Insurance Company
Employee's Name	**1.**_____	**1.**_____
Employee's Social Security #	**2.**_____	**2.**_____
Employee's Date of Birth	**3.**_____	**3.**_____
Employer/Business Name	**4.**_____	**4.**_____
Employer/Business Address	**5.**_____	**5.**_____
	City_____ **Zip**_____	**City**_____ **Zip**_____
Insurance Company Name	**6.**_____	**6.**_____
Insurance Company Address	**7.**_____	**7.**_____
	City_____ **Zip**_____	**City**_____ **Zip**_____
Group Plan Number	**8.**_____	**8.**_____
Insurance ID Number	**9.**_____	**9.**_____

Family Members Covered **Names and Dates of Birth**

_____

_____

(Continued on back)

DENTAL QUESTIONNAIRE

Name_____ Today's Date _____

1. Have you or any members of your family been to Mauldin Family Dentistry previously? _____
2. If yes, which family members? _____
3. Is there someone we may thank for referring you? _____
4. Purpose of this Dental Visit? _____
5. Have you seen a Dentist / Dental professional in the last 5 years? _____
   Dentist's Name/Dental Practice Name _____ City/State_____
   Date of last dental examination _____ Date of last dental X-rays _____
6. Are you having pain or discomfort at this time? _____
7. Are there any growths or sore places in your mouth? _____
8. Do you have trouble chewing or catching food between your teeth? _____
9. Do you have pain in or near your ears? _____
10. Do you habitually clench your teeth during the day or night? _____
11. Have you been told you have gum problems, or do your gums bleed? _____
12. **WOMEN:** Are you/do you think you could be pregnant? (*Please inform us before X-rays are taken*) _____
13. Is there anything you dislike about your smile, do you have questions about cosmetic dentistry, or would you like to consider whitening your teeth? _____
14. Is there anything related to your medical/dental history not indicated above that you would like to discuss?
    _____

I, _____, agree that the information provided above is accurate and true, to the best of my knowledge. I will be responsible for informing Mauldin Family Dentistry - prior to treatment - of any changes in my (or the patient's health history), and understand that providing incorrect information can be dangerous to my (or the patient's) health. I authorize treatment of myself (or the patient named above), including x-rays and anesthetic, and agree to pay all fees for such treatment.

Signature _____ Date _____

Relationship to Patient _____