SUMMIT DENTAL CARE

Today's Date: ____________________

Patient Information

Patient Name: ________________________________ Sex: M ☐ F ☐ Date of Birth: ______________

Address: ____________________________________ City: ________________ Zip: ___________

Home Phone #: _______________ Work Phone #: _______________ Cell Phone #: ________________

Employed by: ___________________________ Occupation: __________________________________

Contact in case of Emergency: __________________________ Phone #: _________________________

Person Responsible for Account: ______________________________

Dental History

Is there a specific problem you would like us to evaluate today? ______________________________

Date of Last Cleaning: _______________ Date of Last Treatment: _______________

How often do you: Brush __________ Floss __________

Yes	No	
____	____	Have you had orthodontics, oral surgery (wisdom teeth), or gum surgery?
____	____	Do you have any problems with TMJ, facial pain, or difficulty opening/closing?
____	____	Do your gums bleed when you brush?
____	____	Have you had any head/neck/jaw injuries?
____	____	Are you satisfied with the appearance of your smile?
____	____	Are you satisfied with how well your teeth function?

Insurance

Insured Employee Name: ____________________________________

Social Security #: ____________________ Date of Birth: ___________

Employer Name: _____________________ Group #: _____________

Insurance Name: _____________________ Phone #: _____________

Address, City, State, Zip: ____________________________________

Covered Dependents:

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I acknowledge that the above information is complete and accurate to the best of my knowledge.

Signature: ____ Date: ____________________