NEW HOPE DENTAL CARE

Patient's full name:_____

Today's date:_____

SS#:_____ **Birth date:**_____

Home #_____ **Cell #**_____ **Work#**_____

Address:_____

Email address:_____

Name of person whose insurance covers patient:_____

Their relationship to patient:_____ **Their birth date:**_____

Their SS#_____ **Employer:**_____

Insurance company:_____

Emergency contact person:_____

Their address:_____

Their telephone numbers:_____

How did you hear about our office?_____

Dental History: Please check all that apply

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clench, grind teeth
- ☐ Dry mouth
- ☐ Pain or noise in ear
- ☐ Painful teeth
- ☐ Use chew or snuff
- ☐ Very anxious dental patient
- ☐ Wore braces
- ☐ Would like to improve my smile

When did you last visit the dentist, and for what?

Your reason for leaving your last dentist?

What brings you to our office?