Dakota Dental and Implant

We would like to get to know you better…

Date: _____

Name: _____

Address: _____

_____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Drivers License #: _____

Social Security #: _____

Date of Birth: _____

Employer: _____

Occupation: _____

Work Address: _____

_____ Work Phone: _____

Spouse's Name: _____

Spouse's Occupation: _____

Spouse's Employer: _____

Address: _____

_____ Phone #: _____

FOR INSURANCE PURPOSES

Name of Insured (Employee with the insurance): _____

Name of Carrier (Insurance Company): _____

Insured's Employer: _____

Social Security #: _____ Group #: _____

Insured's Birth Date: _____ Employee ID #: _____

Are you covered by another plan? _____ If so, name of carrier: _____

Social Security #: _____ Group #: _____

Employer: _____ Birth Date: _____

Financial Reference: _____

Who may we thank for referring you to our office? _____

Reason for Today's Visit: _____

Previous Dentist: _____

Address: _____

Date of last dental care: _____ Date of last dental X-rays: _____

Check (✓) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____