MODERN DENTISTRY OF NOVATO

PATIENT INFORMATION

Name: _____ **Birthdate:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Email Address: _____ **Notification Preference:** ☐ **Text** ☐ **Email**
Sex: ☐ **M** ☐ **F** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Partnership**
Spouse, Partner or Parent Name: _____
Person to contact in case of emergency: _____
Responsible Party (if not patient) _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
How did you learn about our practice or whom may we thank for referring you? _____

DENTAL INSURANCE:

Insurance company: _____ **Phone:** _____
Subscriber Name: _____ **Birthdate:** _____
Subscriber ID# (OR) Social Security #: _____ **Plan Group #:** _____
Employer or School:_____ **Phone:** _____

SECONDARY DENTAL INSURANCE:

Insurance company: _____ **Phone:** _____
Subscriber Name: _____ **Birthdate:** _____
Subscriber ID# (OR) Social Security #: _____ **Plan Group #:** _____
Employer or School:_____ **Phone:** _____

DENTAL HISTORY:

Reason for today's visit: _____
Date of last dental care visit: _____ **Date of last dental x-rays:** _____
Former dentist's name: _____ **Phone:** _____
Check if you have any of the following:

- **Bad breath**
- **Bleeding gums**
- **Clicking or popping jaw**
- **Food collection between teeth**
- **Grinding/Clenching teeth**
- **Loose teeth or broken fillings**
- **History of deep cleaning/SRP**
- **Sensitivity to temperature/sweets**
- **Sensitivity when biting/chewing**
- **Sore or growths in your mouth**

Patient or Guardian Signature: _____ **Date:** _____