JEFF LEECH
FAMILY DENTISTRY

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## About You

Today's date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

Email: _____

Home Phone #: (  ) - _____ Cell Phone #: (  ) - _____

Work Phone #: (  ) - _____ Ext. _____

Where do you prefer to receive your calls ☐ Home ☐ Work ☐ Cell

When are the best time(s) to reach you? _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate: ____/____/_____ Age: _____

SS#: _____

Employer: _____

How long there? _____ Occupation: _____

Who may we THANK for referring you? _____

Other family member(s) seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____ Phone #: (  ) - _____

## Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Describe your current dental health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

How long has it been since your last dental cleaning? _____

Have you ever been diagnosed with periodontal/gum disease? ☐ Yes ☐ No

Has a dentist ever recommended for you to have your teeth cleaned more frequently than every 6 months? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Have you ever had a complication associated with any previous dental work? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Would you like to have whiter teeth? ☐ Yes ☐ No

## Dental Insurance

Primary Insurance: ☐ Yes ☐ No

Insurance Company: _____

Policy Holder's Name: _____

Patient's Relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child

Policy Holder's SS#: _____

Policy Holder's Birthdate: _____ /_____ /_____

Policy Holder's Employer: _____

Subscriber ID: _____ Group #: _____

Secondary Insurance: ☐ Yes ☐ No

(If no, please see Responsible Party Section)

Insurance Company: _____

Policy Holder's Name: _____

Patient's Relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child

Policy Holder's SS#: _____

Policy Holder's Birthdate: _____ /_____ /_____

Policy Holder's Employer: _____

Subscriber ID: _____ Group #: _____

## Responsible Party

Person Responsible for Account _____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent

Home Phone #: (  ) - _____ Work Phone #: (  ) - _____

Cell Phone #: (  ) - _____ Email: _____

Address: _____

SS#: _____ Birthdate: _____/_____/_____

Employer: _____

For your convenience we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Credit Card

☐ I wish to discuss the office's payment policy