Welcome!!!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us become better acquainted, please fill out this form completely in ink and sign all the pages. If you have any questions or concerns, please let us know.

PATIENT INFORMATION (CONFIDENTIAL)

Full Name: ______________________ What would you like us to call you? ____________
Address: ______________________ City: ____________
State & Zip: ____________ Age: ______ Sex: _____ Birthdate: ________ Marital Status: _____
Home Phone: ____________ Work Phone: ____________ Mobile/Pager #: ____________
E-mail Address: ______________________ Would you like a reminder call for your appointments? YES NO
How would you like us to verify your appointments? ☐ HOME PHONE ☐ WORK PHONE ☐ MOBILE/PAGER ☐ E-MAIL
Social Security #: ______________________ Driver's License #: ____________
Employer Name (Patient/Parent's): ______________________
Employer's Address: ______________________
Whom may we thank for referring you? ______________________
Main reason for your visit today? ______________________
Previous Dentist: ______________________ Date of Last Dental Visit: ____________

PARENT *(for minors)* /SPOUSE INFORMATION *(Please fill out completely.)*

MOTHER or WIFE		FATHER or HUSBAND	
Name:		Name:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Work Phone:		Work Phone:	
DL#	DOB:	DL#	DOB:
SS#		SS#	

Person Financially Responsible: ______________________
****Please list any of your family members who are patients in our office?** ____________

PATIENT DENTAL HISTORY	YES	NO
Do you floss regularly?		
Have you ever had instruction on the correct method of brushing your teeth?		
Have you had any instructions on the care of your gums?		
Are your teeth sensitive to hot or cold liquids/foods?		
Are your teeth sensitive to sweet or sour liquids/foods?		
Do you feel pain in any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any difficult extractions in the past?		
Have you had any prolonged bleeding following an extraction?		
Have you had any orthodontic work?		
Is there anything about the appearance of your teeth that you would change? (What?)		
Have you had any bad experiences in a dental office? If yes, please briefly explain		

I authorize MI MAINSTREET DENTISTRY *to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.*

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Signature of patient (or parent if patient is a minor)