Welcome to Advanced Dental Center

Name:_____ **Preferred Name:**_____
Last *First* *Middle Initial*

Soc. Sec #: _____-_____-_____ **Age:**_____ **Sex:** ( )M ( ) F **Birthdate:**_____/_____/_____

Home Phone:_____ **Cell Phone**:_____ **E-mail:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Marital Status: ( )Single ( )Married ( )Divorced ( )Other ( )Child **Occupation:** _____

How Did You Hear About Us? _____

Emergency Contact:_____ **Relationship:** _____ **Phone:**_____-_____-_____

Primary Insurance (including BCBS Medical)

Ins. Company Name: _____ **Subscriber ID /Soc Sec #:** _____ **Birthdate:**_____/_____/_____

Subscriber:_____ **Relationship to Patient:** _____
Last *First* *Middle Initial*

Address (If Different from Patient):_____ **City:**_____ **State:**_____ **Zip:**_____

Subscriber's Employer:_____ **Occupation:**_____

Names of Other Dependents Covered Under this Plan: _____

Additional Insurance

Is Patient Covered by Additional Insurance? ( )Yes ( ) No

Ins. Company Name: _____ **Subscriber ID /Soc Sec #:** _____ **Birthdate:**_____/_____/_____

Subscriber:_____ **Relationship to Patient:** _____
Last *First* *Middle Initial*

Subscriber's Employer:_____ **Occupation:**_____

Names of Other Dependents Covered Under this Plan: _____

Dental History

Reason for Today's Visit_____ **Date of Last Dental Visit**_____ **Date of Last Dental X-rays**_____

Former Dentist Name_____ **Phone No. /E-mail**_____

Why Did You Leave Your Previous Dentist? _____

Check If You Have Had Problems with Any of the Following:

- Bad breath
- Bleeding gums
- Clicking or popping of jaw
- Jaw pain
- Food collection between teeth
- Grinding or clinching teeth
- Loose teeth or broken fillings
- Periodontal Disease
- Sensitivity to hot or cold
- Sore or growths in mouth