Keenan W. Smith DMD PA
general dentistry

PATIENT INFORMATION

Patient name:_____ Cell #:_____ Work #:_____ Home #:_____

Address:_____ City, State, Zip:_____

Date of Birth:_____ Social Security #:_____ E-mail:_____

Who referred you to our office?_____

ACCOUNT INFORMATION

Person responsible for this account (NOT insurance):_____

Address:_____ City, State, Zip_____

Cell #:_____ Work #:_____ Home #:_____

Place of Employment:_____ Work address:_____

I understand I am responsible for the full amount of this account.

Signature_____

INSURANCE INFORMATION

Is patient covered by insurance? Circle One: Yes or No Name of Policy Holder:_____

Social Security # of Policy Holder:_____ Group Name:_____ Group #:_____

SECONDARY INSURANCE (IF APPLICABLE)

Is patient covered by insurance? Circle One: Yes or No Name of Policy Holder:_____

Social Security # of Policy Holder:_____ Group Name:_____ Group #_____

DENTAL HISTORY

How long since your last dental visit?_____ Reason for last dental visit:_____

How often do you brush?_____ How often do you use dental floss?_____ Do you smoke or chew tobacco in any form?_____

Do you have any painful areas, sensitive teeth, or bleeding gums at this time?_____

Have you ever had any treatment for gum problems or gum disease and when:_____

Have you ever had any serious trouble associated with any previous dental treatment?_____

What is the main reason for your dental visit now?_____

I hereby authorize Dr. Keenan Smith and his staff to provide me with routine dental treatment.

Signature of patient (Parent or Guardian)_____ Date _____