CENTERBURG DENTAL CARE

3927 Columbus Road
Centerburg, Ohio 43011
740-480-8162
www.centerburgdentalcare.com

WELCOME TO OUR OFFICE!

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION

Patient Name _____ Today's Date _____/_____/_____
Social Security #_____ Birthdate _____/_____/_____
Home Phone _____ Cell Phone _____
Address _____
City _____ State _____ Zip _____
Email _____ Driver's License # _____
When confirming appointments how do you prefer to be contacted: ☐ Phone ☐ Email ☐ Text Message
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Patient's or Parent's Employer _____ Work Phone _____
Work Address _____
City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____
Work Phone _____ Cell Phone _____
Emergency Contact _____ Phone _____

How did you hear about our office? (Check all that apply)

☐ TV ☐ Google ☐ Website ☐ Yellow Pages ☐ Drive By ☐ Brochure ☐ Other

☐ Friend _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____
Social Security #_____ Birthdate _____/_____/_____
Name of Employer _____ Date Employed _____/_____/_____
Work Phone _____ Union or Local # _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

DENTAL HISTORY

Previous Office _____ Date of last dental visit_____

Do you like your smile?	☐ Yes	☐ No	Do you have dentures / partials?	☐ Yes	☐ No
Do your gums bleed?	☐ Yes	☐ No	Prolonged bleeding following extractions?	☐ Yes	☐ No
Are your teeth Sensitive / In Pain?	☐ Yes	☐ No	Interested in learning brushing techniques?	☐ Yes	☐ No
Sores / lumps / bumps in mouth?	☐ Yes	☐ No	Grind / clench / issues related to TMJ?	☐ Yes	☐ No
Reaction to Dental anesthetic or dental work?	☐ Yes	☐ No	Scale of 1-10 how fearful are you of dental work? (1 being not afraid at all)	_____	