WELCOME TO BREMEN FAMILY DENTISTRY

1712 West Plymouth Street • Bremen, IN 46506 • Phone: (574) 546-2851 or (800) 445-9864

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient Name: _____ Birthdate: ____/____/____
LAST NAME FIRST NAME M.I.

SSN: _____ Driver's License Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

E-mail Address: _____

Sex: M or F Single Married Widowed Divorced

Patient Employed by: _____ Occupation: _____

Work Phone: _____ Is it okay to call you at work? Yes No

HOW WOULD YOU PREFER WE CONFIRM APPOINTMENTS:

Phone: _____ Text Message: _____

E-mail: _____

Spouse Name: _____ SSN: _____ Birthdate: ____/____/____

Spouse Employed by: _____ Occupation: _____

Work Phone: _____

Who is responsible for this account? _____

PLEASE PRESENT INSURANCE CARD TO THE RECEPTIONIST FOR COPYING.

I understand that I am responsible for ALL fees not covered by insurance. In the event that this account becomes delinquent, I agree to pay all costs of collection, including, but not limited to, reasonable attorney fees and monthly service fees (which may not exceed 18% APR).

Signature of Responsible Party: _____ Date: ____/____/____

PLEASE COMPLETE IF PATIENT IS A MINOR

Father's Name: _____ SSN: _____ Birthdate: ____/____/____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

Place of Employment: _____ Work Phone: _____

Mother's Name: _____ SSN: _____ Birthdate: ____/____/____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

Place of Employment: _____ Work Phone: _____

PLEASE COMPLETE OTHER SIDE OF THIS FORM

How did you find out about our office?

❑ Family/Friend/Coworker ❑ Phone Book ❑ Newspaper
❑ Sign ❑ Internet ❑ Radio

Date of last dental exam?_____ Date last dental x-rays taken? _____
What is the name/address of your previous dentist? _____

_____

Have you ever had a bad experience with dental treatment? ❑ YES ❑ NO
If yes, please explain: _____

_____

Do you like the appearance of your teeth and your smile? ❑ YES ❑ NO
If not, please explain: _____

_____

Do you have spaces that you don't like? ❑ YES ❑ NO
If yes, please explain: _____

_____

Do you like the color of your teeth? ❑ YES ❑ NO
If not, please explain: _____

_____

Do you like the shape of your teeth? ❑ YES ❑ NO
If not, please explain: _____

_____

Are your teeth…
Chipped ❑ YES ❑ NO Protruding ❑ YES ❑ NO
Hidden ❑ YES ❑ NO
If yes, please explain: _____

_____

Are there old fillings or dental work you don't like looking at? ❑ YES ❑ NO
If yes, please explain: _____

_____

What would you like to change the most in the appearance of your teeth?

_____

_____

_____

How would you like your teeth to look?

_____

_____

_____