Northside Dental

FAMILY, COSMETIC, AND IMPLANT DENTISTRY

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Thank you for choosing Northside Dental. All information is kept strictly confidential.

Today's Date: _____

Patient Name: _____
First MI Last Preferred Name

Social Security #: _____ Driver's License #: _____ Date of Birth: _____

Email Address: _____

Phone: _____
Home Mobile Other

Address: _____
Street Apt# City State Zip Code

Employer: _____ Occupation: _____

Emergency Contact: _____
First Last Relationship

Emergency Contact Phone: _____
Home Mobile Other

Insurance Information

Insurance Company: _____ Toll Free Phone: _____

Are you the subscriber? □ Yes □ No (If yes, skip to Group #)

Subscriber: _____
First Last Social Security # Date of Birth

Group #: _____ Subscriber ID # (may be SSN): _____ Employer: _____

How Did You Hear About Us? (Please select all that apply)

□ Friend or family member
Name: _____

□ Dental insurance

□ Internet
- □ Google
- □ Yahoo
- □ Yelp
- □ CitySearch
- □ Facebook
- □ Linkedin

□ Other: _____

Dental History

Why are you here today? _____

Who was your last dentist? _____ When was the last time you saw a dentist? _____

Why did you decide to change dentists? _____

Has a physician or dentist ever recommended you take antibiotics before dental treatment? □ Yes □ No

Have you ever had an unpleasant dental experience? □ Yes □ No

If yes, please describe: _____

How is your current dental health?

- □ Good
- □ Average
- □ Needs improvement
- □ Not sure

Do your gums bleed when you brush or floss?

- □ Never
- □ Sometimes
- □ Most of the time

Do you grind your teeth? □ Yes □ No

If you could change anything about the appearance of your smile, what would it be?

_____

I attest that the information provided above is accurate to the best of my knowledge.

_____
Patient Name

_____
Signature of patient, parent or guardian