

Welcome To Power Road Dental Care

Patient's Name _____
Married__ Single__ Divorced__ Widowed__ Separated__
Sex: M__ F__ Birth date _____ Social Security # _____
Address _____
City/State/Zip _____
Home Ph # _____ Work Ph # _____ Cell Ph # _____
E-mail Address _____
Employer _____
Business Address _____
Occupation _____
College Student? Yes/ No Full or Part Time? College/University _____

We expect payment in full at each appointment. For your convenience we offer the following methods of payment, please circle the option you prefer.

Cash Visa/MC/Discover/Am. Express Check Driver's license # _____

Primary Dental Insurance Information

Subscriber's name _____
Subscriber's address _____
Subscriber's SS# _____ Birthday _____
Relationship to patient _____
Subscriber's employer _____
Business address and phone _____
Insurance Company _____ Phone # _____
ID# _____ Group # _____

Secondary Dental Insurance Information

Subscriber's name _____
Subscriber's address _____
Subscriber's SS# _____ Birthday _____
Relationship to patient _____
Subscriber's employer _____
Business address and phone _____
Insurance Company _____ Phone # _____
ID# _____ Group # _____

Dental History

Reason for today's visit _____ Last dental visit _____
Date of last x-rays _____ cleaning _____

Check if you have or have ever had any of the following:

Bad breath__ Bleeding gums__ Clicking or popping of jaw__ Trauma to head or neck__

Sensitivity to: Sweets__ Hot__ Cold__ Biting pressures__

Sores or growths in your mouth__ Do you grind your teeth? Yes No

Are you happy with the appearance of your teeth? Yes No

