JACK OHANESIAN DDS
FAMILY DENTISTRY

Patient Information & Health History

Patient Information

Patient Name:_____

Male__ Female__ Single__ Married__ Divorced__ Widowed__

Birthdate:____/____/_____ Age:____ SS#:_____/____/_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Pager:_____

Employer:_____

Whom may we thank for referring you?_____

In the event of an emergency, is there someone we should contact?

Name:_____Relationship:_____

Work Phone:_____ Home Phone:_____

Spouse Information

Spouse's Name:_____

Employer:_____

SS#:_____/_____/_____ Work Phone:_____

Birthdate:____/____/_____ Cell Phone:_____

Responsible Party Information

(A person, not an insurance company name)

Person Responsible for Account:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

SS#:_____/_____/_____ Birthdate:_____/____/_____

Primary Dental Insurance Information

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone Number:_____

Group/Plan Policy or Local #:_____

Insured Person's Name:_____Relation:_____

Insured's Birthdate:____/____/_____ SS#:_____/____/_____

Insured's Employer:_____

Employer Phone Number:_____

Are you covered by a second dental insurance: ___Yes ___No

Credit Card #_____Exp. Date_____

Your Dental Concerns

Why did you come to the dentist today?_____

_____

Are you in pain? ___Yes ___No

Are you interested in complete care, or do you just want to treat the immediate problem?_____

Do you have any special concerns or requests?_____

Are you happy with your smile? ___Yes ___No

Do you like the color/shape of your teeth? ___Yes ___No

Do your gums bleed? ___Yes ___No

What are the best days/times for you to have treatment? _____

_____

When and where are the best times to reach you?_____

_____

Are you available for 7:00 AM appointments? ___Yes ___No

Are you available to be called on short notice to come in for appointments? ___Yes ___No