THE WORTHINGTON DENTAL GROUP

7227 N. High Street, Suite 1 Worthington, Ohio 43085 PH: 614-885-2022 FX: 614-505-3384

Name_____SSN_____Today's Date_____

Date of Birth_____Age_____Sex M F If minor, Parent's Name_____

Address_____City_____

State_____Zip Code_____Email_____

Home Phone_____Work Phone_____Cell Phone_____

Occupation_____Employed By_____

Marital Status (circle) M S W D Spouse's Name_____

Spouse's Occupation_____Employed By_____

Person Responsible for this Account_____

Whom may we thank for referring you?_____

Form of Payment: ( ) Cash ( ) Credit Card ( ) Check ( ) Insurance *As a benefit to our patients, we submit insurance. However, patient portion is due at time services are rendered.

INSURANCE

Primary Policyholder_____Primary Insurance Company_____DOB_____

Employer_____ID#_____Group_____SSN_____

Secondary Policyholder_____Secondary Insurance Company_____DOB_____

Employer_____ID#_____Group_____SSN_____

DENTAL HISTORY

Purpose of your visit?_____

Former Dentist_____Address_____

Have you had any problems with previous dental treatment?_____

Check if you have had problems with the following:

__Bad taste in your mouth	__Broken fillings	__Bleeding Gums
__Bad odor in your mouth	__Periodontal treatment	__Clicking or popping of jaw
__Discomfort in head/face	__Sensitive to hot/cold	__Swelling or bumps
__Grinding your teeth	__Sensitive to biting	__Food collecting between teeth

Are you dissatisfied with your teeth and their appearance? YES NO

Do you feel that in the past you have required a lot of dental work? YES NO