509 W Hanley Ave, Ste 102
Coeur D'Alene, ID 83815

Patient Name_____ Preferred Name_____

Birthday____/_____/_____ SSN_____-_____-_____ Sex Male Female

Mailing address_____

City_____ State_____ Zip Code_____

Best Phone Number to Reach You _(_____)_____-_____

Names of immediate family members who are patients at this office_____

_____

Employer_____ Email Address _____

How were you referred to us? _____

DENTAL HEALTH HISTORY

- Does it make you anxious to go to the dentist? Yes No
- Are you dissatisfied with the appearance of your teeth? Yes No
- Are your teeth sensitive? Yes No
- Do you gag easily? Yes No
- Do you have sore or bleeding gums? Yes No
- Do you clench or grind your teeth? Yes No
- Have you ever had braces or any other orthodontic treatment? Yes No
- Are you concerned about snoring? Yes No

Agreement to pay for treatment:
The patient and responsible party agree to pay for all charges submitted by this office during the course of treatment at the time of service. If insurance is involved an estimated amount of coverage will be determined and the patient will be responsible for the amount that insurance is estimated to not cover and after insurance pays, any amount unpaid will also be the patient's responsibility.

_____ _____
Signature of patient or responsible party Date Signed