MAIN STREET DENTAL

your main address for gentle convenient care

New Patient Form

Name (first and last)* _____

Date of Birth *_____

Address *_____

Address line 2 _____

City _____ State _____ ZIP _____

Employer _____

Occupation _____

Home Phone_____ Cell Phone_____

Work Phone _____

Responsible Party (if patient is a minor)_____

(first and last name)_____

Date of Birth _____

Address _____

Address Line 2 _____

City _____ State _____ ZIP _____

Home Phone_____ Cell Phone_____

Work Phone _____

Primary Dental Insurance Company _____

Address _____

Address Line 2 _____

City _____ State _____ ZIP _____

Subscriber Employee Name

First_____ Last _____

Subscriber Employer _____

Date of Birth _____ Social Security Number _____

Member # _____Group # _____

Phone _____

Relationship to Subscriber_____

Secondary Insurance Company _____

Address _____

Address Line 2 _____

City _____State_____ ZIP _____

Subscriber Employee Name

First_____Last _____

Subscriber Employer _____

Date of Birth _____ Social Security Number _____

Member # _____Group # _____

Person to contact in Case of Emergency *

First_____ Last _____

Phone * _____

Is another member of your family a patient of Main Street Dental? *

- ☐ Yes
- ☐ No

If yes, what is their name? _____

General Questions:

How did you hear about Main Street Dental? _____

_____

How long since your last dental visit? _____

Why did you leave your previous dentist? _____

_____

_____

What is the primary reason for this dental visit? _____

_____

_____

Are you experiencing dental pain or sensitivity?

☐ Yes

☐ No

If yes, how long? _____

How do you feel about your teeth in general? _____

Are you happy with the appearance of your teeth? _____

_____

How often do you have your teeth cleaned? _____

Have you had any unpleasant dental experiences in the past? _____

_____

_____