# *Metroplex Implants & Family Dentistry*

4231 Sigma Road Suite 100 Dallas, TX 75244

Phone: (972) 233-5447 | Fax: (972) 702-8887 | www.metroplexdentistry.com


## NEW PATIENT INFORMATION

DATE _____

NAME _____

DATE OF BIRTH _____ AGE _____

HOME STREET ADDRESS _____

CITY _____ ZIP _____

EMAIL _____

HOME PHONE _____ WORKPHONE _____

OCCUPATION _____ EMPLOYED BY _____

SS# _____ DRIVER'S LICENSE # _____

NAME OF SPOUSE _____ EMPLOYED BY _____
(Name of parent if patient is a minor)

DENTAL INSURANCE _____ YES; _____NO NAME OF COMPANY _____

SECONDARY INSURANCE ____ YES; ____ NO NAME OF COMPANY _____

NAME OF YOUR DENTIST _____

HOW LONG HAVE YOU SEEN THIS DENTIST? _____

ADDRESS _____ PHONE _____

WHO REFERRED YOU TO THIS OFFICE? _____

NAME OF YOUR PHYSICIAN _____

ADDRESS _____ PHONE _____

WHAT IS YOUR UNDERSTANDING ABOUT WHY YOU WERE SENT HERE? _____

_____.

HAVE YOU HAD ANY PERIODONTAL TREATMENT BEFORE? ____ YES; ____ NO; WHEN? _____

BY WHOM? _____

IS YOUR MOUTH UNCOMFORTABLE NOW (or in the recent past)? _____