

# Cleveland Dental Associates

Cosmetic & Preventive Dentistry

## Personal Profile

First Name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
I like to be called: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: # \_\_\_\_\_  
What number would you like us to call on regarding you appointments? \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Married: \_\_\_\_\_ Single: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Minor: \_\_\_\_\_  
Driver's License# & State: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

## Responsible Party Information if patient is a minor

Responsible party First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Driver's License# & State: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Who may we thank for referring you to our practice?

## Previous Dentist Information

Previous dentist name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Last date seen by your previous dentist? \_\_\_\_\_  
Treatment rendered: \_\_\_\_\_ May we contact them for any reason? \_\_\_\_\_

## Primary Insurance Information

Insurance Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insured's First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Insured's Place of Employment: \_\_\_\_\_

## Who should we contact in the unlikely event of an emergency?

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_  
Cell: \_\_\_\_\_