

Cleveland Dental
Cosmetic & Preventative Dentistry

PERSONAL PROFILE

First Name: _____ MI: _____ Last Name:

_____ I like to be called: _____ Male Female

Address: _____ City:

_____ State: _____ Zip: _____ Driver License # & State:

_____ Date of Birth: _____ Social Security #:

Married: Single: Separated: Divorced: Widowed:

Minor:

Home: # _____ Work #: _____ ext: _____ Cell:

Name of Employer: _____

Occupation: _____ City: _____

State: _____

Email Address: _____ you can now confirm appointments by Email, access your account, appointments and treatment information. Please ask us for more information.

IF PATIENT IS A MINOR : RESPONSIBLE PARTY INFORMATION

Responsible party First Name: _____ Mi: _____ Last Name:

_____ 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: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Insured's First Name: _____ Mi: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____

Insured's Place of Employment: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work: _____ ext: _____

Cell: _____