Ramzi Sawabini, D.D.S.
Toan D. Nguyen D.D.S.

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

PATIENT INFORMATION

Date:_____ Patients Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Email:_____
Birth Date: _____ Social Security: _____ Drivers License:_____
Emergency Contact:_____ Phone Number: _____
☐ Responsible party is also Policy Holder for Patient
☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient:_____
Address:_____
City, State, Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Birth Date: _____ Social Security: _____ Drivers License: _____
Sex: ☐ Male ☐ Female Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Employment Status: ☐Full Time ☐Part Time ☐Retired Student Status: ☐Full Time ☐Part Time
E-mail: _____ ☐ I would like to receive correspondences via E-mail

INSURANCE INFORMATION

Insured Name: _____ Insured Social Security: _____
Insurance Company: _____ Group #: _____
Insurance Company Address: _____ Phone #: _____
Insured's Employer: _____
Is policy connected with your union? ☐Yes ☐No Name of Union: _____ Local #:_____
Do you have dual coverage? ☐Yes ☐No If Yes, Please complete the following secondary insurance information.
Insured Name: _____ Insured Social Security: _____
Insurance Company: _____ Group #: _____
Insurance Company Address: _____ Phone #: _____
Insured's Employer: _____
Is policy connected with your union? ☐Yes ☐No Name of Union: _____ Local #:_____

DENTAL INFORMATION

Do your gums bleed when you brush? ☐Yes ☐No
Are your teeth sensitive to heat or cold? ☐Yes ☐No Pressure? ☐Yes ☐No Sweets? ☐Yes ☐No
Do you grind or clench your teeth? ☐Yes ☐No
Do you have any fear of dental work? ☐Yes ☐No
Have you ever had braces? ☐Yes ☐No If Yes, when: _____
Date of last dental visit:_____ What was done at that time? _____
Former Dentist Name: _____ City: _____
How would you describe your current dental problem? _____
_____
How do you feel about the appearance of your teeth? _____