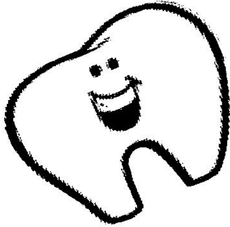
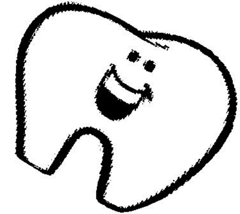
Welcome to Shelley Dental



(208)-357-2400



PATIENT INFORMATION FORM

Patient's Name:______________________ Birth-Date:__________ Sex: M F
Residence Address:______________________ City:__________ State:____ Zip:______
Mailing Address:______________________ City:__________ State:____ Zip:______
Home Phone #:______________ Daytime #:______________ Cell #:______________
E-mail Address:______________________ Patient S.S.N.:______-____-________
Employer:______________________ Work Phone #:______________
Spouse or Parents' Name(s):______________________________________
Spouse or Parent's Birth-Date:______________ S.S.N: _____-____-_______ Cell #:______________
Mode of Payment for your portion of service? □ Cash / □ Check / □ Credit Card
Insurance Company Name:______________________________________
Address:______________________________________
Subscriber:______________ Employee ID #:______________ Group #:______________
Subscriber's Birth-Date:______________ S.S.N.: _____-____-_______ Date Employed:______________
Employer:______________ Employer Address:______________________
Secondary Insurance Company Name:______________________________________
Address:______________________________________
Subscriber:______________ Employee ID #:______________ Group #:______________
Subscriber's Birth-Date:______________ S.S.N.: _____-____-_______ Date Employed:______________
Employer:______________ Employer Address:______________________
Whom may we thank for referring you? Name:______________________

DENTAL HISTORY

Reason for today's visit:______________________________________
Former Dentist:______________________________________
Address:______________________________________
Date of last dental visit:______________ Date of last dental X-rays:______________
Checkmark (✓) if you have had any of the following:

□ Bad Breath □ Grinding Teeth □ Sensitivity to heat □ Sensitivity to cold
□ Bleeding Gums □ Loose teeth / broken fillings □ Sensitivity to sweets □ Periodontal treatment
□ Clicking/Popping Jaw □ Food collection between teeth □ Sensitivity to biting □ Sores or growths in mouth

Is there anything you don't like about your smile?:______________________
What radio station do you enjoy the most?:______________________