James Center Dental Excellence
1622 So. Mildred, Suite B
Tacoma, Washington 98465
253-460-3431

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 _____ Patient's Name_____
Last First Middle

Address _____
Street City State Zip

Email Address _____Home Ph. # (___) _____ Work Ph. # (___)_____
By providing your email you are giving permission to send you information via email.

Soc. Sec. # _____-____-_____ Drivers Lic. # _____ Birthdate_____ /_____ /_____ Sex M F

If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you_____ Relationship _____

Complete Address_____ Ph. # (___) _____

Emergency Contact _____ Ph. # (__) _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Soc. Sec. #_____-_____-_____ Birthdate _____/_____/_____ Relationship to Patient_____

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Ph.# (____) _____Work Ph.# (____) _____

Previous Address (if less than 3 years)_____

Employer_____Occupation_____No. Years Employed_____

Employer Address_____

Spouse's Name_____ Relationship to Patient_____

Soc. Sec. #_____-_____-_____ Birthdate_____/_____/_____ Work Ph. # (___) _____

Employer_____ Occupation_____ No. Years Employed_____

Employer Address_____

Insurance Information

Insured's Name_____ Insured's Soc. Sec # _____

Insurance Company_____ Group #_____

Insurance Co. Address_____ Ph. # (____) _____

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's Name_____ Insured's Soc. Sec # _____

Insurance Company_____ Group #_____Local #_____

Insurance Co. Address_____ Ph. # (____) _____

Insured's Employer_____ Ph. # (____) _____

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__

Date of last dental visit_____What was done at the time? _____

Former Dentist Name_____ City_____

How would you describe your current dental problem?_____

_____

How do you feel about the appearance of your teeth?_____