

**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

Home Ph. # (\_\_\_\_) \_\_\_\_\_ Work Ph. # (\_\_\_\_) \_\_\_\_\_ 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? \_\_\_\_\_