Steve M. Mosby, D.D.S

Family and Cosmetic Dentistry

Patient Information

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Today's Date _____

Patient's Name _____ ☐ Male ☐ Female
Last *First* *Mi*

Address _____
Street *City* *State* *Zip*

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

E-Mail Address _____ @ _____

Date of Birth _____ Age _____ Driver's License No. _____ Social Security No. _____-_____-_____

Employer _____ Occupation _____

Business Address _____
Street *City* *State* *Zip*

Name of Spouse _____ Work Phone ( ) _____
Last *First* *Mi*

Emergency Contact _____ Emergency Phone ( ) _____
Name

Name of Dental Insurance Co. _____ Group No. _____

Address of Dental Insurance Co. _____
Street *City* *State* *Zip*

Insurance Company's Phone ( ) _____ Insurance I.D. No. _____

Name of Insured _____ Birth Date of Insured _____ Social Security No. of Insured _____-____-_____

Employer of Insured _____ Do you have Secondary Insurance? ☐ Yes ☐ No

Whom may we thank for referring you? _____

If Patient is a Minor, Give Name of Both Parents or Name of Legal Guardian.

Name of Parents or Legal Guardian _____ _____
Mother *Father*

Work Phone Numbers ( ) _____ ( ) _____
Mother *Father*

Social Security Numbers _____-_____-_____ _____-_____-_____
Mother *Father*

Dental History and Information

Name of previous Dentist _____ Phone ( ) _____

Have you ever had an unfavorable reaction from a local anesthetic? ..... ☐ Yes ☐ No

Have you ever had any serious trouble associated with any previous dental treatment? ..... ☐ Yes ☐ No

How long since your last Full Mouth X-Rays? _____ Bite-Wing X-Rays? _____

How long since your last dental treatment? _____

Do you like the appearance of your teeth? ☐ Yes ☐ No

Are your teeth as straight as you would like them to be? ☐ Yes ☐ No

Are you happy with the length, width and shape of your teeth? ☐ Yes ☐ No

Do you think you have a "Gummy" Smile? ☐ Yes ☐ No

Do you have any chipped teeth? ☐ Yes ☐ No

Do you have any spaces between your teeth? ☐ Yes ☐ No

Do you have any discoloration, stains or spots on your teeth? ☐ Yes ☐ No

Would you like for your teeth to be whiter? ☐ Yes ☐ No

Do you have any dental work that you do not like? ☐ Yes ☐ No

Do have any silver fillings that you would like changed to tooth colored fillings? ☐ Yes ☐ No

Do you know anyone who has any cosmetic dentistry that interests you? ☐ Yes ☐ No

From the above questions, which concerns you the most? _____

If you could change anything about the appearance of your teeth, what would it be? _____

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