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Welcome!

Please fill out the following form
to help us give you the best treatment possible.

Name: _____ Nickname: _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____

Birth date: _____ Ethnic Origin: _____ Age: _____ Gender: _____

Social Security Number: _____ Email: _____

Employer: _____

Whom can we thank for referring you to us? _____

Dentist's name: _____ Last Visited: _____

Spouse's name: _____ Spouse's Social Security #: _____

Spouse's employer: _____ Spouse's work #: _____

Spouse's Date of Birth: _____ Other family members treated here: _____

Name and Age of Children: _____

In case of **Emergency**, call: _____ Phone: _____

Any **Medical Alert** or **Allergies**: _____

Do you have any medical concerns? _____

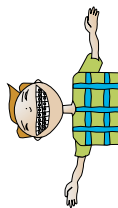
Physician's name: _____

Please list any medications that you are currently taking: _____

Are there any problems that may prohibit us from providing you with successful treatment?

Do you have any habits that we should be aware of? _____
(nail biting, lip biting, tongue thrust, grinding, clenching, snoring)

Have you had any injuries to the face, mouth, or teeth? _____



(Over)

Please describe your main concerns in detail that brought you to our office:

Please circle the picture that you feel best represents your appearance.



Do you feel that your concerns are more related to:

_____Cosmetics _____Prevention _____Function

What do you like to do during your spare time? (Optional) _____

Financial Information: I hereby authorize release of any information which pertains to the treatment or Insurance Benefits for the above patient. I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and have completed all of the answers. I certify this information is true and correct to the best of my knowledge.

Please sign: _____ Date: _____

Dental Insurance Company: _____

Insurance Mailing Address: _____

Subscriber's Name: _____ Subscriber's Social Security # _____

Subscriber's Date of Birth _____ Policy # _____ Group # _____

Please complete the following information if someone other than patient is responsible for bill:

Responsible Party's Name: _____ Social Security #: _____

Responsible Party's Address: _____

Relationship to patient: _____

Thank you for your time!