Jonathan F. Powell, D.D.S.

Patient Information (Confidential)

Name: ______________________________ Date: ____________
Address: ______________________________ City: ______________ State:______ Zip:________
Home Phone: ____________________ Cell Phone:________________ Work Phone:______________
SS#__________________________ Driver license#________________ Birth date______________

Email: ____

Employer: ______________________________________

Spouse's name: ____________________________________ Cell phone #: __________________
Spouse's employer:__________________________________ Work #: ______________________
Spouse's address (if different): ____

How did you hear about our office? ____

Insurance Information

Company: __________________________________ Phone #: __________________________

Name of Insured______________________________ Policy #: __________________________

Birth date_____________________________ SS#_______________________________

Relationship: (circle) spouse parent self guardian

Dental Information

Are you having a specific dental problem? (explain)

When was your last dental visit? ____
What treatment did you receive? ____
When did you last have x-rays? ______________________ What kind? __________________
Name of previous dentist ______________________________ City/State: __________________

If you could change something about your smile, what would it be? ____________________________

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Signature of Patient or Parent/Guardian if Minor ____________________________________