WELCOME TO STONEBRIDGE DENTAL!
STEPHEN R. CASH, D.D.S., P.C.

Please complete this questionnaire carefully. The information is confidential and helps us provide you and your family with complete, quality dental care.

Patient Name _____ Date of Birth_____
Sex: M F Marital Status: S M Div. Sep. Widow (Circle) SS#_____

Address_____ City_____ Zip_____
Home# _____ Work# _____ Cell# _____
Email Address_____

Responsible Party _____
Billing Address if Different_____
City_____ Zip_____
Place of Employment_____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION
Name of person that insurance is carried under_____
Their SS# _____Their Date of Birth_____
Name of Insurance Co. and Mailing Address_____
_____
Group# _____ID# _____Telephone# of Ins. Co._____
Which family members are on this policy?_____

DENTAL HISTORY
Date of last dental exam _____Previous dentist_____
Reason for last dental visit _____May we request your records?_____
How many times a day do you brush your teeth? _____Do you floss daily?_____
Do your gums bleed when you brush? _____Would you like whiter teeth?_____
Do you feel your fillings are unattractive? _____Do you have dental implants?_____
Do you wear dentures or partials? _____Would you like straighter teeth?_____
Have you ever had an unusual reaction to dental anesthetic? _____If yes, please explain: _____
_____
Reason for seeking treatment today_____

EMERGENCY CONTACT: Name:_____ Phone:_____

I, the undersigned, authorize Dr. Stephen R. Cash and the staff of Stonebridge Dental to take x-rays, impressions, photographs, and/or any other diagnostic aids deemed appropriate by Dr. Cash to make a thorough diagnosis of my dental needs. I further authorize Dr. Stephen R. Cash and the staff of Stonebridge Dental to perform any and all forms of treatment, administration of medication and therapy as necessary.

Patient Signature _____ Date _____