Steven A. Beuligmann, D.D.S.

Cosmetic & Family Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. *We look forward to working with you in maintaining your dental health.*

Patient Information

Date _____ Home Phone _____

Name _____ Soc. Sec. # _____

Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Email Address _____ Cell Phone _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person responsible for Account _____

Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

❑ Yes, I have a secondary carrier. Name _____

Dental History

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check ( ) if you have had problems with any of the following:

- ❑ Bad breath
- ❑ Been told you snore
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss? How often do you brush? _____

Please Complete Both Sides