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

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

Patient's 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 is 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 may 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 hereby authorize Doctor or his staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with patient. I further authorize and consent that Doctor choose and employ such assistance as deemed fit..

Patient Signature _____ **Date** _____