

Greenbelt Smiles

Dr. Martha Bustillo & Dr. Ashley Featherston

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date _____

If minor, parents names _____ Birthday _____ SS# _____

Home phone _____ Cell Phone: _____ Work phone _____

Email: _____ Would you like to receive messages via email or Text: _____

Emergency Contact name: _____ Phone number: _____

Mailing address _____ City _____ State _____ Zip _____

If student name of School/College: _____ City _____ State _____ Full time Part time

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ Unmarried

Whom may we thank for referring you to our office? _____

BILLING AND INSURANCE INFORMATION: Not covered by dental insurance

Name of insured: _____ Relationship to Patient: _____

Birthday: _____ Name of Employer: _____ ID Number: _____

Group Number: _____ SS# _____ Dental Insurance Co. _____ Phone Number _____

Is Patient Cover by additional insurance? Yes No

Name of insured: _____ Relationship to Patient: _____ Birthday: _____

Name of Employer: _____ ID Number: _____ Group Number: _____

Social Security number _____ Dental Insance Co. _____ Phone Number: _____

Is this person currently a patient in our office? _____

DENTAL HEALTH HISTORY

| Yes | No | Yes | No |
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Do you feel twinges of pain when your teeth come in contact with:
 Hot food or liquid?
 Cold food or liquid?
 Sours?
 Sweets?
 Have you ever notice slow-healing sores in or about your mouth?

How often do you brush? _____

How often do you floss? _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____