SMILE CENTER
DENTAL CARE
32114 1st Ave S, Ste 100 | Federal Way, WA 98003
P: 253 · 326 · 6230 | F: 253 · 661 · 2505 | www.smilecenterdentalcare.com

PATIENT INFORMATION

Patient _____ **O Male** **O Female**
Last First M.I.

Preferred Name _____ **Birthdate** ____/____/____ **SS#**_____

Cell Phone# _____

- Would you like to receive text messages for appointment reminders and general health information? **O Authorize** **O Decline**

E-mail _____

- Would you like to receive emails for appointment reminders and general health information? **O Authorize** **O Decline**

Address _____
Street City State Zip

Occupation _____ **Employer** _____

Parent/Guardian's Name_____ Birthdate of Parent/Guardian_____
(Patient under 18 years old)

Emergency Contact's Name_____, **Relation**: _____, **Phone #**_____

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

INSURANCE INFORMATION

- **Please Have Your Insurance Card and Photo I.D. Ready At Time Of Check In.**

DENTAL HISTORY

Previous Dentist/Office _____ **City, State** _____

When was your last dental exam and cleaning? _____

What is your immediate dental concern? _____

Have you had orthodontic treatment (braces)? _____ **Would you like to straighten you teeth?** _____

Do you wear a night guard? _____ **Do you have jaw discomfort or clicking?** _____