Carter Periodontics & Implant Dentistry
2283 Raleigh Court • Clarksville, TN 37043 • (931) 614–6603

Patient Intake

Patient Information

Please Print
Patient Name: _____ Date: _____

Birth Date:_____ Social Security #: _____ Sex: M F

Address: _____ City _____ Zip _____

Cell #: _____ Is it OK to Text? Yes No Home Phone#: _____

Work # _____ E-Mail :_____ Is it OK to E-mail? Yes No

Emergency Contact: _____ Relationship: _____ Phone : _____

Spouse or Responsible Party Information (if other than Patient)

Name : _____ Birth Date: _____ Social Security #: _____

Address: _____ City: _____ Zip: _____

Cell #: _____ Home #: _____ Work#: _____

Dental Insurance Information

*Primary Insurance
Name of insured:_____ Insured's Birth Date: _____

ID or SS#:_____ Group#:_____ Home #: _____ _____

Employer Name: _____ If military, Rank: _____

Patient's Relationship to insured: Self Spouse Child Other: _____

Insurance Plan: _____ Phone #: (_____)_____

*If you have a secondary Insurance, Please write the information on the back of this form.

Patient Dental History

Referring Dentist: _____ Practice Name: _____

Date & location of last Dental Hygiene Appointment: _____

Have you had Scaling and Root planning in the past?: Yes or No If so, when? _____

Are you on a Periodontal Maintenance Schedule?: Yes or No

Do You Pre-Medicate Before Appointments?: Yes or No If yes, list reason_____

What are we seeing you for today? _____

_____