Welcome to Dental Care of Cuba!

Thank you for selecting our dental healthcare team. Please fill out this form completely. If you have any questions or concerns, please ask for assistance. We will be glad to help.

~Patient Information~

Name_____ Date of birth_____

Preferred Name _____ Social Security # (***please fill out***) _____

Home Address_____
Street City State/ Zip

Home Phone_____ Work _____ext_____ Cell _____

Are you: □ a Minor □ Single □ Married □ Divorced □ Widowed □ Male □ Female

Email _____ Do you want to receive email correspondence: □ Yes □ No

*** We send reminders to confirm each appointment via email or text message. If you do not provide an email address or cell phone #, we will call you to verbally confirm each appointment.**

If patient is a student, name of school/college_____

Person to contact in case of emergency_____ Phone_____

~Responsible Party~ (If different than patient)

If the patient is a minor, this section MUST be filled out with the name and information of the person bringing them to appointment.

Person responsible for this account _____ Relationship to patient_____

Birth date_____ Social Security #_____ Phone #_____

Address (if different from patient)_____

Employer_____ Work Phone_____

~Insurance Information~

Person who carries insurance_____Relationship to patient_____

Employer_____ Work Phone _____

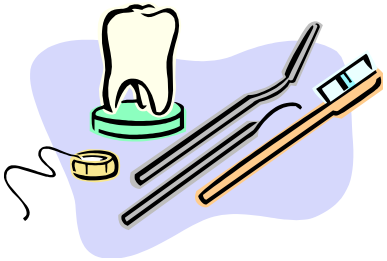
Birth date_____ Social Security #_____ Date Employed_____

Insurance Company_____ ID#_____ Group #_____

If patient has a Managed Care Insurance, please write CIN# here _____

Thank you for filling out this form completely and accurately

~Dental Health Questionnaire~



Welcome to our office! This questionnaire is designed to help us get to know you better. Please answer the question in the way that you understand it. You may leave a question blank, if you prefer. There is no right or wrong answer. This information is kept in your patient record and is confidential.

~How did you find out about our office? (Check all that apply)

Friend, Family member Co-worker Phonebook Insurance Facebook

Office website Local business referral Newspaper Radio Other

Please list name of person that referred you if you wish. _____

~How would you describe the general condition of your mouth (teeth, gums, etc)?

~Are you experiencing pain at the present time? If yes, what do you think is causing it?

~What dental needs do you think you have? What would you like us to do for you at this office?

~Have you had dental care in the past? ___yes ___no. If yes, when was your last visit? What was done for you at that time?

~Are you pleased with your smile?
Is there anything you would like to change about your smile?

~Do you have any concerns about receiving dental treatment you would like to make us aware of?

~Additional Comments:

Visit our website at: www.dentalcareofcuba.com

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