Aaron Tropmann, DDS., PA.
Gary D. Oyster, DDS.

Patient Information (Confidential)

Full Name_____ _____ Todays Date: _____
Birthdate_____ SS#_____ Driver's License#_____
Male_____ Female_____
Minor_____ Single____ Married_____ Separated_____ Divorced _____Widowed _____
Address_____
City_____ State _____ Zip _____
Home phone_____ Work _____ Cell _____
E-mail_____ If you are a College Student, name of School _____
City _____ are you full-time or part-time (circle one)
Emergency Contact _____ **Phone #** _____
Date of your last Dental visit _____ **Date of last Dental x-rays** _____
Whom may we thank for referring you? _____

Responsible Party (if other than patient)

Person responsible for this account _____ Relationship to Patient _____
Phone # _____
Address if different from above _____ City_____ Zip _____
Is this person currently a patient in our practice? Yes_____ No_____

Dental Insurance Information

Name of Insured/Subscriber_____ Relationship to Patient _____
Social Security #_____ Birthdate of Insured _____
Name of Employer _____Union or local #_____
Insurance Company _____ Phone#_____
ID#_____ Group # _____
Ins Co. Address _____ City _____ State _____

Is patient covered by another insurance plan? _____ If so, be sure to tell our front desk
Reason for today's visit_____ Date of last Dental visit _____
Date of last Dental x-rays _____ Name of former Dentist _____
Have you had any of the following problems:

_____Bad Breath	_____ Food collection between teeth	_____ Sensitivity to cold/hot
_____Bleeding Gums	_____ Grinding teeth	_____ Sensitivity to sweets
_____Clicking or popping jaw	_____ Loose teeth or broken fillings	_____ Sensitivity when biting
_____Crooked teeth	_____ Periodontal treatment	_____ Sores or growths in mouth
		_____ yellow/discolored teeth

How often do you brush? _____ **How often do you floss**? _____