Family & Cosmetic DENTISTRY OF THE ROCKIES

Dr. Travis R. Willey, D.D.S.
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Patient Information

Name:________________________ Date:__________SS#__________________

Address:______________________ Birth Date:____________ Age:___________

City/State/Zip:_________________________ M____F____Marital Status:________

Occupation:___________________ E-mail address:_______________________

Employer:____________________ Home Phone#_______________________

Employment Address:________________ Cell Phone#_______________________

Referring Dentist:________________ Work Phone#_______________________

Do you have dental insurance? Y / N If yes who is it with_______________________

Person responsible for this account?____________ Phone#_______________________

In case of emergency, please contact:____________ Phone#_______________________

Spouse or Parent Information

Name:________________________ Birth Date:____________

Occupation:___________________ Employer:_______________________

Cell Phone#___________________ Work Phone#_______________________

Dental Insurance Information

Insurance Company:________________ Insurance Group#__________________

Insurance Company Address:_______________________________________

Insurance Company Phone #____________________

Employee Name:________________ Employer Name:__________________

Employee ID#or SS#________________ Employee Birth date:_______Relationship to Patient__________

Dental Concerns: **Please circle if you have had or now have any of the following:**

Headaches	Jaw Pain	Congested Ears	Neck Ache
Ringing Ears	Clenching	Loose Teeth	Difficulty Chewing
Sensitive Teeth	Grinding	Frequent waking	Halitosis (bad breath)
Bleeding Gums	Jaw Popping	Dry Mouth (Xerostomia)	

Y / N Allergy or hypersensitivity to any metals (jewelry, etc.)?
Y / N Have you ever been told that you have periodontal disease?
Y / N Has snoring or sleep apnea been a problem for you?