

**Milford Dental Group**

**Anna Chisilenco Raho D.D.S.**

**Patient Information**

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ E-mail: \_\_\_\_\_

SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_ How did you Hear about us: \_\_\_\_\_

**Primary Dental Insurance Information**

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Address if different: \_\_\_\_\_ Contact phone number: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Subscriber's SSN/ID: \_\_\_\_\_

Insurance Company and phone number: \_\_\_\_\_

**Secondary Dental Insurance Information**

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Address if different: \_\_\_\_\_ Contact phone number: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Subscriber's SSN/ID# \_\_\_\_\_

Insurance Company and phone number: \_\_\_\_\_

**Dental History**

Former Dentist: \_\_\_\_\_ Date of last cleaning: \_\_\_\_\_

How often do you brush: \_\_\_\_\_ floss: \_\_\_\_\_ Bleeding Gums: Y N

Bad breath \_\_\_\_\_ Sensitive teeth \_\_\_\_\_ Broken teeth/fillings \_\_\_\_\_ Jaw pain \_\_\_\_\_ Loose teeth \_\_\_\_\_

Sores or growths in mouth \_\_\_\_\_ Grinding teeth \_\_\_\_\_ Food traps between teeth \_\_\_\_\_

Sensitivity to any of the following: Cold \_\_\_\_\_ Hot \_\_\_\_\_ Sweets \_\_\_\_\_ Biting/Chewing \_\_\_\_\_

Dental concerns: \_\_\_\_\_

\_\_\_\_\_

Previous dental experience: \_\_\_\_\_

\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to contact our office.