

**Sorin N. Muntean DDS**  
110 East Thousand Oaks Boulevard  
Thousand Oaks, CA 91360  
(805) 373-9475

**PATIENT INFORMATION**

Date \_\_\_\_\_ Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
If patient is a minor, give parent or guardian's name \_\_\_\_\_  
Name of nearest relative not living with you \_\_\_\_\_  
Address of relative \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
What do you enjoy doing for fun/hobbies/extracurricular activities? \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_ Martial Status \_\_\_\_\_  
Residence \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_  
Previous address (if less than 3 years) \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # of years employed \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Spouse Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # of years employed \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured Social Security # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_  
Is policy connected to your union? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Union \_\_\_\_\_ Local # \_\_\_\_\_  
Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ \*If yes, please complete the following secondary insurance information  
Insured's Name \_\_\_\_\_ Insured Social Security # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Phone \_\_\_\_\_

**DENTAL INFORMATION**

Do your gums bleed when you brush? Yes \_\_\_\_\_ No \_\_\_\_\_  
Are your teeth sensitive to heat or cold? Yes \_\_\_\_\_ No \_\_\_\_\_ Pressure? Yes \_\_\_\_\_ No \_\_\_\_\_ Sweets? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you grind or clench your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you have any fear of dental work? Yes \_\_\_\_\_ No \_\_\_\_\_  
Date of last dental examination \_\_\_\_\_ What was done at that time? \_\_\_\_\_  
How would you describe your current dental problem, if any? \_\_\_\_\_  
\_\_\_\_\_  
How do you feel about the appearance of your teeth? \_\_\_\_\_  
\_\_\_\_\_