15160 NW Laidlaw Rd Ste 202
Portland, Oregon 97229
in Bethany Village
Tele: 503-533-2330
Fax: 503-533-2331
www.bethanydentistpdx.com

Hillside Dental at Bethany

Patient Information

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Birth Date: _____ Social Security Number: _____
Email Address: _____
Employer: _____
Previous Dentist's Name: _____
Current Physician's Name: _____

Responsible Party Information

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Birth Date: _____ Social Security Number: _____
Email Address: _____
Employer: _____

How did you find us?
☐ Bethany Family Values Magazine ☐ Brochure ☐ Internet ☐ Live nearby
☐ Referred by friend, family or another person ☐ Referred by insurance company ☐ Other
If you were referred, whom may we thank for referring you? _____

Dental History

Why have you come to the dentist today? _____
When was the last time you saw a dentist? _____

Do you have any of the following concerns?

☐ Frequent Headaches	☐ Gum Disease	☐ Jaw Joint (TMJ/TMD) Pain
☐ Hot/Cold Sensitivity	☐ Bleeding Gums	☐ Grinding or Clenching
☐ Sensitivity to Sweets	☐ Painful Gums	☐ Painful Teeth

Do you need to be premedicated with antibiotics before dental treatment? ◯ Yes ◯ No
Are you interested in a whiter smile? ◯ Yes ◯ No
Would you like to straighten your smile? ◯ Yes ◯ No
Do you have any metal fillings you would like to replace? ◯ Yes ◯ No

15160 NW Laidlaw Rd Ste 202
Portland, Oregon 97229
in Bethany Village
Tele: 503-533-2330
Fax: 503-533-2331
www.bethanydentistpdx.com

Hillside Dental at Bethany

Emergency Contact

Name: _____
Relation: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

I have dental insurance: ○ **Yes** ○ **No**

Primary Insurance Information

Subscriber Name: _____
Employer: _____
Insurance Company: _____
Subscriber Date of Birth: _____
Subscriber ID Number or Social Security Number: _____
Group ID Number: _____
Insurance Phone Number (on back of card): _____

Secondary Insurance Information

Subscriber Name: _____
Employer: _____
Insurance Company: _____
Subscriber Date of Birth: _____
Subscriber ID Number or Social Security Number: _____
Group ID Number: _____
Insurance Phone Number (on back of card): _____