

Today's Date _____

Patient Name _____ Name you wish to be called _____

Home Address _____ Home Phone (____) _____

City _____ State _____ Zip Code _____ Work Phone (____) _____

E-Mail (will not be shared) _____ Cell Phone (____) _____

Best Time and Place to Reach You _____

Sex: M__ F__ Single __ Married __ Birthdate _____ Your Social Security # _____

Employer _____ Occupation _____

Employer Address _____ Employer Phone (____) _____

Spouse Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ Occupation _____

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name _____ Relationship to you _____

Address and Phone Number of Emergency Contact Person _____

Who is responsible for this account? _____ Relationship to patient _____

Whom may we thank for referring you? _____

INSURANCE

Dental Insurance Carrier _____ Group # _____

Is patient covered by additional insurance ? yes __ no __ Subscriber's name _____

Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____

Dental Insurance Carrier _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

DENTAL HISTORY

Reason for today's visit _____

Date of last dental visit _____ Date of last dental X-rays _____

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

Please check if you have any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Blisters on lips or mouth |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Smoking | <input type="checkbox"/> Fingernail biting |
| <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Chewing tobacco |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Floss shredding or breaks | <input type="checkbox"/> Clenching teeth |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Lip or cheek biting |
| <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Sensitivity to biting | <input type="checkbox"/> Swollen or bleeding gums |

Are you happy with the appearance of your teeth? _____ If you answered no, please explain _____

