WELCOME

PATIENT INFORMATION

Patient _____ Date _____

Home Address _____

Mailing Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # _____

Occupation _____

Employer _____

Employer's Address _____

Employer's Phone _____

Spouse's Name _____

Birthdate _____

Occupation _____

Spouse's Employer _____

Spouse's Employer Address _____

Spouse's Employer Phone _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, Insurance Co. _____

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, 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's Signature

_____ _____
Relationship Date

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Cell _____ Spouse's Work _____

Best time and place to reach you _____

EMERGENCY CONTACT: (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

If you had a magic wand, what would you change about your teeth?

_____

Please mark "Yes" or "No" to indicate if you have or had any of the following:

Bad taste	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Loose teeth or broken filling	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Sensitivity to cold/heat/sweets	☐ Yes	☐ No
Dark teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Unsightly teeth	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No			
Grinding teeth	☐ Yes	☐ No	How often do you floss? _____		
Gums swollen or tender	☐ Yes	☐ No	How often do you brush? _____		