

W E L C O M E

PATIENT INFORMATION

Date _____ ID#/SS# _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

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

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 Signature

Relationship

Date

PHONE NUMBERS

Home(_____) _____ Work(_____) _____ Ext _____ Spouse's Work(_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Check (✓) if you have had any of the following:

Bad breath Yes No

Bleeding gums Yes No

Blisters on lips or mouth Yes No

Burning sensation on tongue

Yes No

Chew on one side of mouth

Yes No

Cigarette, pipe, or cigar smoking

Yes No

Clicking or popping jaw

Yes No

Dry mouth

Yes No

Fingernail biting

Yes No

Food collection between the teeth

Yes No

Foreign objects

Yes No

Grinding teeth

Yes No

Gums swollen or tender

Yes No

Jaw pain or tiredness

Yes No

Lip or cheek biting

Yes No

Loose teeth or broken fillings

Yes No

Mouth breathing

Yes No

Mouth pain, brushing

Yes No

Orthodontic treatment

Yes No

Pain around ear

Yes No

Periodontal treatment

Yes No

Sensitivity to cold

Yes No

Sensitivity to heat

Yes No

Sensitivity to sweets

Yes No

Sensitivity when biting

Yes No

Sores or growths in your mouth

Yes No

How often do you floss? _____

How often do you brush? _____