Patient Information:

Name ______ (First MI Last) Age ______ Sex ______ Home Phone ( ) ______

Address ______ Apt. No. ______ Work Phone ( ) ______

City ______ State ______ Zip ______ Other Phone ( ) ______

Birthdate ______ (Month Day Year) SSN ___ - ___ - ___ ______ (Drivers License Number, State)

Employer / Occupation ______ Address ______

In case of emergency, contact: ______ Relationship ______ Phone ( ) ______

Are any of your family members patients of this practice? ☐ YES ☐ NO Name ______ Relationship ______

If the person responsible for the account is different than the patient, please fill in this section:

Name ______ (First MI Last) Relationship ______ Home Phone ( ) ______

Address ______ Apt. No. ______ Work Phone ( ) ______

City ______ State ______ Zip ______ Employer ______

Birthdate ______ (Month Day Year) SSN ___ - ___ - ___ Address ______

Primary Dental Insurance (Leave blank only if no dental benefits)

Name ______

Address ______

City ______ State ______ Zip ______

Phone ______ Group No. ______

Policy Number ______

Name of insured if different than patient:

Name ______ Relationship ______

Address ______

City ______ State ______ Zip ______

Birthdate ______ SS Number ______

Employer ______

Secondary Dental Insurance

Name ______

Address ______

City ______ State ______ Zip ______

Phone ______ Group No. ______

Policy Number ______

Name of insured if different than patient:

Name ______ Relationship ______

Address ______

City ______ State ______ Zip ______

Birthdate ______ SS Number ______

Employer ______

Dental History

What is the reason for this appointment? ______

Are there any specific dental problems we should be aware of? ______

What was the purpose of your last dental appointment? ______ When was that? ______

When was the last time you had a dental cleaning? ______ Name of previous dentist? ______

When was the last time you had dental x-rays? ______ Why, which teeth? ______

How would you describe your dental health? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Do you think you have any decay or cavities? ☐ YES ☐ NO How often do you brush? ______

Do your gums bleed easily when brushing or flossing? ☐ YES ☐ NO How often do you floss? ______

Do you suffer from chronic bad breath or bad taste? ☐ YES ☐ NO

Do you have any jaw joint cracking or pain? ☐ YES ☐ NO

Whom may we thank for referring you to our office? ______

Patient treatment consent

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1½% per month.

Patient / Parent or Guardian Signature: ______ **Date:** ______

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