Welcome To Our Practice

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____

SS # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ❑ M ❑ F Age _____ Weight _____

Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

Spouse's SS# _____

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 certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable forrelated services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

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 (____) _____

Pharmacy Name and Town _____ Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Referring Dentist _____

City/State _____

Date of last Dental Visit _____

Date of last X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	❑ Yes	❑ No	Burning Sensation on Tongue	❑ Yes	❑ No	Mouth breathing	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No	Chew on one side of the mouth	❑ Yes	❑ No	Mouth pain, brushing	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No	Cigarette, pipe, or cigar smoke	❑ Yes	❑ No	Orthodontic treatment	❑ Yes	❑ No
			Clicking or popping jaw	❑ Yes	❑ No	Pain around ear	❑ Yes	❑ No
			Dry mouth	❑ Yes	❑ No	Periodontal treatment	❑ Yes	❑ No
			Fingernail biting	❑ Yes	❑ No	Sensitivity to cold	❑ Yes	❑ No
			Food collection between the teeth	❑ Yes	❑ No	Sensitivity to heat	❑ Yes	❑ No
			Foreign objects	❑ Yes	❑ No	Sensitivity to sweets	❑ Yes	❑ No
			Grinding/Clenching teeth	❑ Yes	❑ No	Sensitivity when biting	❑ Yes	❑ No
			Gums swollen or tender	❑ Yes	❑ No	Sores or growths in your mouth	❑ Yes	❑ No
			Jaw pain or tirredness	❑ Yes	❑ No	How often do you floss? _____		
			Lip or cheek biting	❑ Yes	❑ No			
			Loose or broken fillings	❑ Yes	❑ No	How often do you brush? _____		