Patient Information:

05182005

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

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

City _____ State _____ Zip _____ Other Phone ( ) _____

Birthdate _____ SSN _____-_____-_____ E-mail Address _____
Month Day Year

Employer Name & Phone _____ Referred by_____

In case of Emergency, Contact: _____ Relationship: _____ Phone ( ) _____

Are any 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 _____ Relationship _____ Home Phone ( ) _____

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

City _____ State _____ Zip _____ Employer ___ _____

Birthdate _____ SSN _____-_____-_____ Employer Phone _____
Month Day Year

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

Name _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Group No. _____

Group Name _____

Name of insured if other than patient:

Name _____ Relationship _____

Address _____

City _____State _____ Zip _____

Birth Date _____SSN_ _____-_____-_____

Employer Name & Phone _____

Do you have secondary insurance? ☐ Yes ☐ No Name of insurance _____

Dental History:

What is the reason for this appointment? _____

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

Do you think you have any cavities or decay? ☐ Yes ☐ No

Do your gums bleed easily when brushing or flossing? ☐ Yes ☐ No

Do you suffer from chronic bad breath or bad taste? ☐ Yes ☐ No

Do you have any jaw joint cracking or pain? ☐ Yes ☐ No

Do you grind your teeth or clench your jaws? ☐ Yes ☐ No

How often do you brush? _____ Floss? _____

How would you describe your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Would you like your smile to look different? ☐ Yes ☐ No

Are any of your teeth sensitive to heat, cold, or pressure? ☐ Yes ☐ No

Have you ever had a bad experience in the dental office? ☐ Yes ☐ No

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

When was the last time you had a dental cleaning? _____ When were the last x-rays taken of your teeth?_____

Patient Treatment Consent

- I authorize the Dentist(s) or designated staff treating me to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the Dentist(s) or staff to perform all recommended treatment and therapeutic procedures, and administer medications as prescribed by the Dentist(s).
- I assign all dental insurance benefits to which I am entitled, as permitted under my dental insurance policy(s), to the Dentist. I allow this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "Signature on File". I grant the right to the Dentist(s) to release health information and dental treatment records, such as x-rays, to my insurance carrier as necessary or requested.
- I understand that I am responsible for payment of dental services provided to the above named patient, my dependents, and/or me and that payment is due at the time of service. I understand that my insurance is an agreement between my insurance company and me. I am responsible for payment of all or any portion of claims that my insurance company does not pay (within 60 days of service). Account balances over 60 days may be assessed a service charge of 1.5% per month. In the event of default, I agree to pay legal interest on the indebtedness together with such collection costs and attorney fees as may be required to effect collection of this note.
- I understand that it is my responsibility to honor all appointments made at this office and that I may be charged for missed appointments that were not rescheduled or canceled with 48 hours of notice.

Patient / Parent or Guardian Signature: _____ Date _____