

**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 \_\_\_\_\_