

PATIENT INFORMATION:

NAME _____ AGE _____ SEX _____ HOME PHONE () _____
FIRST MI LAST

ADDRESS _____ APT. No. _____ WORK PHONE () _____

CITY _____ STATE _____ ZIP _____ EMPLOYER _____

BIRTHDATE _____ SSN _____ OCCUPATION _____
MONTH DAY YEAR

IN CASE OF EMERGENCY, CONTACT: _____ RELATIONSHIP _____ PHONE () _____

ARE ANY OF YOUR FAMILY MEMBERS PATIENTS OF THIS PRACTICE? YES NO NAME _____ RELATIONSHIP _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IF THE PERSON RESPONSIBLE FOR THE ACCOUNT IS DIFFERENT THAN THE PATIENT, PLEASE FILL IN THIS SECTION:

NAME _____ RELATIONSHIP _____ HOME PHONE () _____
FIRST MI LAST

ADDRESS _____ APT. No. _____ WORK PHONE () _____

CITY _____ STATE _____ ZIP _____ EMPLOYER _____

BIRTHDATE _____ SSN _____ OCCUPATION _____
MONTH DAY YEAR

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? _____

- 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

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 WERE THE LAST FULL MOUTH X-RAYS TAKEN OF YOUR TEETH? _____

HOW WOULD YOU DESCRIBE YOUR DENTAL HEALTH? EXCELLENT GOOD FAIR POOR

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.

PREFERRED METHOD OF PAYMENT

Payment in full by cash / check

Payment in full by VISA / MC

Copayment in full

Patient / Parent or Guardian Signature: _____

Date: _____

