## WELCOME

## PATIENT INFORMATION | DENTAL INSURANCE

Date		· v	Vho is respon	sible for	this account?	
SS/HIC/Patient ID #		Relationship to Patient				
Patient						
Address			Group #			
City		Is patient covered-by additional insurance?   Yes No				
State	S	Subscriber's Name				
E-mail		en e	Relationship to	Patient		
Sex M F Age			nsurance Co.			
Birthdate			Group #			
☐ Married ☐ Widowed ☐ Separated ☐ Divorced		☐ Minor A	SSIGNMENT	AND REL	EASE my dependent(s), have insurance	
			Na Na	ame of Ins	surance Company(ies) and	assign directly to
Occupation			or.			surance benefits,
Patient Employer/School		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.				
Employer/School Address						
Employer/School Phone (	والاختراب المالية المساولة المساولة	The above-named doctor 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 for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.				
Spouse's Name						
Birthdate						
SS#			Signatu	re of Patie	ent, Parent, Guardian or Personal Rep	resentative
Spouse's Employer			Please print	name of	Patient, Parent, Guardian or Personal	Representative
			r lease print	manne or	Tatient, Farent, Guardian of Fersonal	ricpresentative
Whom may we thank for referring	ig your			Date	Relationship to	Patient
PHONE NUM	1BERS					
		_ Work ()		Ext	Cell Phone ()	
Spouse's Work ()		Best time and place to rea				
IN CASE OF EMERGENCY, CO				old.)		
Name			Relationship			
Home Phone ()			Work Phone (			
DENTAL HIST	ORY					
Reason for today's visit		Burning sensation on tongue	e 🔲 Yes	□ No	Mouth breathing	Yes N
		Chew on one side of mouth		□ No	Mouth pain, brushing	☐ Yes ☐ N
Former Dentist_		Cigarette, pipe, or cigar smo Clicking or popping jaw	oking Yes	☐ No	Orthodontic treatment Pain around ear	Yes N
City/State		Dry mouth	☐ Yes	□No	Periodontal treatment	Yes N
Date of last dental visit		Fingernail biting	☐ Yes		Sensitivity to cold	☐ Yes ☐ N
		Food collection between the to		□ No	Sensitivity to heat	☐ Yes ☐ N
Date of last dental X-rays		Foreign objects Grinding teeth	☐ Yes	☐ No	Sensitivity to sweets Sensitivity when biting	Yes N
Place a mark on "yes" or "no" to indicate if you have had any of the following:		Gums swollen or tender	Yes	□ No	Sores or growths in your mouth	Yes N
Bad breath	☐ Yes ☐ No	Jaw pain or tiredness	Yes	No	How often do you floss?	
Bleeding gums	Yes No	Lip or cheek biting	Yes	□ No		
Blisters on lips or mouth	☐ Yes ☐ No	Loose teeth or broken fillings	s Yes	☐ No	How often do you brush?	