Zubke
Family Dentistry

Patient Information and Dental Insurance

Patient's Legal Name_____ Male_____ Female_____ SS#_____

Address_____ City_____ State_____ Zip_____

Age_____ Birth Date_____ Home Phone #_____ Work Phone #_____

Single, Married or Divorced?_____ Spouse's Name_____ SS#_____

Spouse's Work Phone #_____ Employer_____ Occupation_____

Child's Father's Name_____ Birth Date_____ SS#_____

Father's Address_____ Home Phone #_____ Employer_____

Child's Mother's Name_____ Birth Date_____ SS#_____

Mother's Address_____ Home Phone #_____ Employer_____

Primary Dental Insurance_____ Group #_____ Contract #_____

Additional Insurance Coverage_____ Group #_____ Contract #_____

Assignment and Release

I, The undersigned certify that I (or my dependents) have insurance coverage and assign directly to Dr. Bruce Carlyon all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize Dr. Carlyon to release all information necessary to secure the payment of benefits. I authorize the use of all insurance submissions.

Signature of Patient or Guardian_____ Date_____

Patient's Dental History

Reason for today's visit_____ How often do you floss?_____ Brush?_____

Former Dentsit_____ Last Dental Visit_____ X-Rays Done? _____

Do you like your smile?_____ Does dental work make you nervous?_____

Please put a "x" next to the conditions that apply to you:

Bad breath_____ Grinding Teeth_____ Sensitivity to sweets_____

Bleeding gums_____ Loose teeth or broken filling_____ Sensitivity when biting_____

Clicking or popping jaw_____ Periodontal treatment_____ Sores or growth in your mouth_____

Food collection between teeth_____ Sensitivity to cold/hot_____