(PLEASE PRINT)

Patient Information

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ____________

Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

Dental Insurance

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ____________ SS# ____________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________ all insurance benefits, if 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.

The above-named dentist 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.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

Phone Numbers

Home (______) ____________ Work (______) ____________ Ext ______ Cell Phone (______) ____________

Spouse's Work (______) ____________ Best time and place to reach you ____________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone (______) ____________ Work Phone (______) ____________

Dental History

Reason for today's visit ______________________

____

Former Dentist ______________________

City/State ______________________

Date of last dental visit ______________________

Date of last dental X-rays ______________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? ______________________

How often do you brush? ______________________

Dental Registration and History