WELCOME, Thank you for selecting our dental healthcare team! We will strive to provide the best possible dental care.

PATIENT INFORMATION

Date________________

Name____ Sex ☐M ☐F Birth date______________________

Address____

City State Zip

Home#(_____)__________________ Cell#(_____)______________ Email______________________

Soc. Sec. #__________________________ Referred by_____________________________

Employer____________________________ Work #(____)_________________ Occupation_________________

If Student-name of school____

RESPONSIBLE PARTY

Name____ Relation to Patient____________________

Birth date______________________ Soc. Sec.#__________________________

Home#(____)_____________________ Cell#(____)__________________ Email________________________

Address____

(if different from patients) City State Zip

Employer____________________________ Work #(____)__________________ Occupation_________________

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co. Name_____________________________

Ins. Address___________________________________

____

Ins. Co. Phone#________________________________

Group # (Plan, local or policy#)___________________

Insured's name_________________________________

Relation to patient______________________________

Insured's Birth date_____________________________

Insured's SS# / ID#_____________________________

Employer______________________________________

SECONDARY INSURANCE

Insurance Co. Name___________________________

Ins. Address_________________________________

____

Ins. Co. Phone#______________________________

Group # (Plan, local or policy#)_________________

Insured's name_______________________________

Relation to patient____________________________

Insured's Birth date___________________________

Insured's SS# / ID#___________________________

Employer____________________________________

Please complete other side.

DENTAL HISTORY

What prompted you to seek dental care at this time?____________________

Are you in dental discomfort today?__________ If so explain____________________

____

How long since your last dental examination__________ Date of last xrays__________

Former Dentist__________ City__________ Phone__________

Why did you leave your last dentist?____________________

Have you experienced any of the following? Check any that may apply.

- ☐ bad breath
- ☐ clenching/grinding
- ☐ periodontal treatment
- ☐ bleeding gums
- ☐ jaw soreness
- ☐ clicking or popping jaw
- ☐ tooth darkening
- ☐ food wedging
- ☐ tooth sensitivity to: ☐ hot ☐ cold ☐ sweets
- ☐ loose teeth
- ☐ frequent headaches

How often do you brush?__________ How often do you floss?__________

Have you ever had any unfavorable reaction from a local anesthetic? Explain__________

Is there anything about dentistry that bothers you? ________ If so explain__________

____

Are you interested in any of the following: Check any or all that apply.

☐ Orthodontics ☐ Cosmetic dentistry ☐ Teeth Whitening ☐ Gum Disease

Please add anything that you feel is important in helping us provide you with the utmost comfort and satisfaction.

____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this information form, to administer such anesthetics, analgesics, sedatives, and x-rays; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Signed:____________________ Date:__________

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally compromised.

FINANCIAL POLICY: Payment is due at or before time of service. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize any release of information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signed:____________________ Date:__________

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC & ADA.

A CONTACT IN CASE OF EMERGENCY:

Name:____________________ Relation:__________

Home#__________ Cell#__________ Work#__________