

# Your Neighborhood Dentist

## Patient Information

Date \_\_\_\_\_ ID#/SS# \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

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, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

## Phone Numbers

Please provide us with your email / or cell phone number so we can send your confirmations for upcoming appointments, specials & coupons!

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Spouse's Work (\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_

**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? \_\_\_\_\_