WELCOME TO OUR PRACTICE

Patient Information

Date

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. First Name M.I. Last Name Preferred

Sex: ☐ Male ☐ Female Birth Date Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

Address City State Zip

Home Tel. Cell Work Ext

Email Social Security Number

How did you learn of our office?

Appt Preference: ☐ None ☐ AM ☐ PM On Short Notice? ☐ Yes ☐ No

Patient Is: ☐ Patient ☐ Policy Holder ☐ Responsible Party

Office Can Send Me: ☐ Emails ☐ Texts ☐ Appointment Reminders

Employed: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ N/A

Student: ☐ Full-Time ☐ Part-Time ☐ N/A School Name

Address City State Zip

In Case of emergency, please contact Tel. Relation

Who is responsible for your account

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other

First Name Last Name Birth Date Tel.

Address City State Zip

S.S. # Employer

Insurance Information

Do you have insurance? ☐ Yes ☐ No

Primary Insurance Company

Insurance Type: ☐ Dental ☐ Medical Employer

Ins. Co. Name I.D. #

Address City State Zip

Group # Group Name

Pol. Holder First Name Pol. Holder Last Name Relation

Birth Date S.S. #

Address City State, Zip Tel.

Secondary Insurance Company

Insurance Type: ☐ Dental ☐ Medical Employer

Ins. Co. Name I.D. #

Address City State Zip

Group # Group Name

Pol. Holder First Name Pol. Holder Last Name Relation

Birth Date S.S. #

Address City State, Zip Tel.

Dental Information

Reason for today's visit

Are you in pain? ☐ Yes ☐ No For How Long?

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ A removable dental appliance
- ☐ Blisters / sores in or around the mouth
- ☐ Prolonged bleeding from an injury / extraction
- ☐ Recent infections or sore throat
- ☐ Lost / broken filling(s)
- ☐ Teeth grinding / clenching
- ☐ Ringing in ears
- ☐ Broken / chipped tooth
- ☐ Gum disease
- ☐ Other
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Burning tongue / lips
- ☐ Toothache
- ☐ Difficulty closing jaw
- ☐ Difficulty opening jaw
- ☐ Loose / shifting teeth
- ☐ Food caught between teeth
- ☐ Swelling / lumps in mouth

My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting

Are you undergoing ortho? ☐ Yes ☐ No

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of patient (Parent or Guardian if Minor)

Date

I hereby acknowledge that I have received a copy of this offices Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website.

Signature of patient (Parent or Guardian if Minor)

Date