

PATIENT INFORMATION & HEALTH HISTORY

Legal Name: _____ Male / Female Birthdate: _____ Age: _____

By what name would you like us to call you? _____ Marital Status: S M W D

Local Address _____ Local Phone: _____
STREET CITY STATE ZIP

Social Security # _____ Occupation _____ Cell Phone: _____

Employer _____ Can we call you at work? Yes No Work Phone: _____

Friend or relative that will be available during your appointments: _____ Phone: _____

Person responsible for your account if other than yourself:

Name _____ Birthdate: _____ Relationship to patient _____

Address _____ Phone: _____
STREET CITY STATE ZIP

Social Security # _____

May we notify this person concerning your diagnosis, treatment, and costs? Yes No

Account to be paid by: Cash Check MasterCard / Visa / Discover

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Subscriber Name _____

Subscriber Name _____

Employer _____

Employer _____

S.S.N. _____ D.O.B. _____

S.S.N. _____ D.O.B. _____

Insurance Carrier _____

Insurance Carrier _____

Please be aware that your dental insurance probably will not pay for the entire amount of your treatment. We cannot always predict your coverage and therefore we request that you pay for your treatment at each visit and collect reimbursement from your insurance company. We will provide your insurance company with any information necessary for you to receive your benefits and reimbursement. You are responsible for any charges not paid by your dental and/or medical insurance.

DENTAL INFORMATION

Who Referred You To Our Office: _____

Reason For Today's Visit: _____

Previous Dentist: _____

NAME STREET CITY STATE ZIP PHONE

Yes No

- Do your gums bleed when you brush?
 Are your teeth sensitive to cold, hot, sweets or pressure?
 Have you had any periodontal (gum) treatments?

Yes No

- Have you had orthodontic (braces) treatment?
 Do you have headaches, ear, or neck pain?
 Do you wear removable dental appliances?

Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____

Date of your last dental exam: _____ Date of last dental x-rays _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

Have you ever whitened or lightened your teeth? _____

Please list anything else you feel is important for us to know. _____

Do you wish to discuss anything about your medical or dental history with the doctor in private? Yes No

PLEASE COMPLETE THE BACK OF THIS FORM, THEN RETURN TO RECEPTIONIST