Patient Information

Patient Name:________________________________(_______________) **Date:**_______________
(Last) (First) (MI) (Preferred Name)

Date of Birth:______________________ **Male**___**Female**___ **Married**__ **Single**___ **Child**___ **Other**____

Phone # for Reminder Call: _______________ **Cell # for TEXT Reminder:** ______________________

Email Address for Reminder: ____________________________________ Home Phone_____________

Address: ____
(Street) (City) (State) (Zip)

Date of Last Dental Visit:____________________ Social Security Number:______________________

If you have ever had heart bypass/stint placed, heart valve surgery, cancer treatments or had an artificial joint placed, you may need written notification from your medical doctor whether or not you can have treatment and if antibiotic premedication is required.

-Do your gums bleed while brushing/flossing? YES____ NO____
-Are your teeth sensitive to any of the following liquids/foods? HOT____ COLD____ SWEET____ SOUR____
-Do you have any sores or lumps in or near your mouth? YES____ NO ____
-Have you experienced any of the following problems in your jaw? CLICKING___PAIN___DIFFICULT OPEN/CLOSE____
-Have you ever had any complications following dental treatment? YES____ NO ____
-If yes, please explain:____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _______________

Social Security #: ____________________________ Birth Date: ____________________________

Phone (Home): ______________ (Work): ______________ Ext:______ (Mobile): ________________

Address: ____
Street Apartment #

____
City State Zip Code

Dental Insurance Information

Primary

Name of Insured **Employee**: ____
Last First MI

Is insured employee a patient? ☐ Yes ☐ No SS # ________________________

Insured's Birth Date: ______________ Subscriber ID# __________________ Group #:__________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Employer Phone Number: ____________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other________________

Insurance Plan Name and Address: ____

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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent for dental treatment to be performed by dentist or staff.

I grant my permission to you or your assignee, to telephone me at all provided numbers and by email to discuss matters related to this form, appointments and/or accounting.

____ Date: ____________ Relationship to Patient: ___________________
Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: ___________________
Signature of guarantor of payment/responsible party