PATIENT INFORMATION - CONFIDENTIAL

Today's Date:

Name: | Social Security #:

FIRST | MI | LAST

Birth Date: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER

Your Address:	Employers Name & Address:
CITY STATE ZIP CODE	CITY STATE ZIP CODE
Home Phone:	Work Phone EXT.:

Cell Phone:

Person to Contact in Case of Emergency: | Phone:

Whom may we Thank for Referring YOU?

INSURANCE INFORMATION

Name of Insured if other than yourself: | Relationship to You:

Insured Parties Social Security #: | Birth Date:

Insurance Company: | Insurance Policy Group #:

Insurance Company Phone Number #:

RESPONSIBLE PARTY

Are you Solely Responsible for this Account? ☐ YES (If YES skip to next Section) ☐ NO

If NO… Name of Responsible Party: | Relationship to You:

Responsible Parties Address:

Responsible Parties Phone Number:

DENTAL HISTORY

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to Hot or Cold liquids/foods?	☐	☐
Are your teeth sensitive to Sweet or Sour liquid/foods?	☐	☐
Do You feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐

	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks, frequently?	☐	☐
Have you had difficulty with previous extractions?	☐	☐
Have you had prolonged bleeding after an extraction?	☐	☐
Have you had any orthodontic work done?	☐	☐
Have you been instructed in the correct brushing techniques?	☐	☐
Have you ever had instructions on gum care?	☐	☐

Date of your last Dental Visit / Cleaning? ____________

AUTHORIZATION

I have read and answered the above questions to the best of my knowledge. I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient or parent if a minor | Date