

Welcome

Chart #:

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

We Would Like to Get to Know You Better!

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

Patient Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ Apt _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate ____/____/____ Married Widowed Single Minor**How did you hear about us?** _____ Separated Divorced Partnered

Why did you leave your last Dentist? _____

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Birthdate: ____/____/____ SS#: _____ Phone#: (____) _____

Patient Employer or School _____ Occupation _____

Employer or School Address _____ Employer/School Phone (____) _____

In case of emergency who should be notified? _____ Phone (____) _____

2nd Emergency Contact: _____ Relation _____ Phone (____) _____

For Insurance Purposes

Subscriber: _____ Birthdate: ____/____/____
*Last Name First Name M.I.*Relation to Patient: Self Spouse Child Other _____ ID#/SS#: _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employer: _____ Occupation: _____

Business Address _____ Business Phone: (____) _____

Insurance Company _____ Insurance Phone: (____) _____

Member ID#: _____ Group#: _____

Names of other dependents covered under this plan _____

Is Patient covered by additional insurance? Yes No

We Want to Take Care of Your Concerns and Needs First...

What are your present dental problems? _____

Do you avoid brushing any part of your mouth? Yes NoDo your gums bleed when brushing? Yes NoAre your teeth sensitive to sweets, hot/cold, or biting pressure? Yes NoI want to know about longer lasting solutions that may cost more. Yes NoAre you dissatisfied with your teeth and their appearance? Yes NoDoes dental treatment make you nervous? No Slightly Moderate VeryI think my dental health is... Excellent Good Fair PoorIf I could change my smile I would make my teeth... Whiter Straighter Close Spaces Repair Chips

Other concerns/needs of mine are _____

I request that all dental benefits, if any, otherwise payable to me or services rendered to be paid to the provider of service. I understand that I am financially responsible for all cares. If insurance proceeds are insufficient to cover my obligations and/or a procedure, I am liable for the shortfall. I authorize the provider to service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services. I am aware that by signing below I certify that all information is complete and correct. This dental office, may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for this dental office, to verify credit history.

Signature of Patient_____
Signature of Responsible Party