WELLCOME



ABOUT YOU

Today's Date:			F	ile #:
Patient Name:				
What You Prefer To Be	Called:_			_ 🗆 Male 🖵 Female
Birthdate://	Age	:	SS#:_	
Mailing Address:				
CITY	`		ATE	ZIP
Home Phone #: (
Work Phone #: ()			Ext:
Cell Phone #: ()			
E-mail Address:				
Referred By:				
Employer:			How	Long?
Employer's Address:				
CITY		ST	ATE	ZIP
Occupation:			* 18 .	
Status: ☐ Minor ☐ Single	Married	☐ Divo	rced 🗆 Sep	arated 🗆 Widowed
Spouse's Name:				
Do you have children?				ny?

4		
	INSURANCE	INF0
Primary Dental Insurance	,	
Co. Name:	*	
Address:		
СІТҮ	STATE	ZIP
Phone #: ()		
Insured's ID#:		
Group # (Plan, Local, or Polic	cy #):	
Insured's Name:		
Relation:	Date of Birth:/	
Insured's Employer:		
Secondary Dental Insura	nce	
Co. Name:		
Address:		
CITY	STATE	ZIP
Phone #: ()		
Insured's ID#:		
Group # (Plan, Local, or Polic	ey #):	*
insured's Name:		
Relation:	Date of Birth:/	
Insured's Employer:	х.	

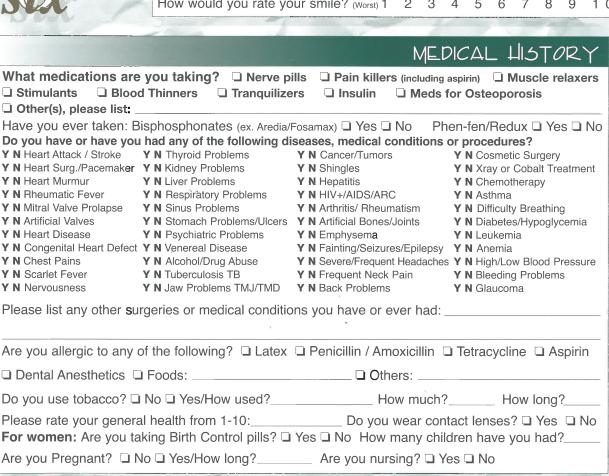
+12500		
1 2 2 B	A <i>CCO</i> UNT	INF0
Person ultimately responsible for	or account	
Name:		
Relation:		
Billing Address:		
	07175	
SS #:	STATE	ZIP
Drivers License #:		
Work Phone #: () Payment method: □ Cash	☐ Check	
☐ Credit Card - Enter card # above (if	accepted)	
I hereby authorize assigned rights and benefits directly services rendered. I fully understable for any balance not paid by my (if offered at this office).	ctly to the provic and I am solely re	der for es p onsi-

IN EVENT OF EMERGENCY
Whom should we contact?
Relation:
Home Phone #: ()
Work Phone #: ()
Cell Phone #: ()
Who is your Medical Doctor?
Medical Doctor's Phone #: ()

PLEASE CONTINUE ON BACK

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	DENTAL INFORMATION
	Reason for today's visit: 🗅 Exam 🕒 Emergency 🗀 Consultation
	Are you in pain? ☐ No ☐ Yes How Long?Please indicate ☑ any of the following problems:
1	□ Discomfort, clicking or popping in jaw. □ Lost/Broken Filling(s) □ Stained teeth
ì	□ Red, swollen or bleeding gums. □ Teeth grinding □ Locking Jaw
	☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
	☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth
d	Other:
1	Do you require pre-medication? Yes No Don't know Previous Dentist: ()
	Name Phone#
	Last Dental exam: / / Last Dental X-rays: / /
	Times a day you brush? Times a week you floss?
	What type of tooth brush bristles do you use? Soft Medium Hard
	How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 1 0 (Best)



We invite you to discuss with us any questions regarding our services. The best Dental health services are based
on a friendly, mutual understanding between provider and patient.
Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been
made with the business manager. If account is not paid within 90 days of the date of service and no financial
arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and
any other expenses incurred in collecting your account.

◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

	i acknowledg	je tnat i nav	e received a co	opy of the	Summary of	of Privacy	Noti	ce.
Initials	- Si a nature				D	ate /	/	,
	5	☐ Adult Patient	☐ Parent or Guard	dian 🗆 S	Spouse			

UP) (OFFI	DATE CE USE)
Initials	/ / Date
Con	nments
Initials	/ / Date
Con	nments
Initials	/ / Date
Con	nments

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□ Spouse