Patient Information	on		De	ental Ins	urance			
Date			Who is responsible for this account?					
SSN #			Relationship to Patient					
Patient Name			Insurance Co					
Address			Is patient covered by insurance?					
Address			Subscriber's Name					
E-mail			Birthdate					
City State Zip			Relationship to Patient					
•			Insurance Co.					
Sex M F Age Birthdate			Group #					
			ASSIGNMENT AND RELEASE					
				I certify that I and/or my dependent(s), have insurance coverage with				
☐ Separated ☐ Divorced ☐ Partnered foryears				Name of Insurance Company(ies)				
Patient Employer/School			Dr all insurance benefits, if					
Occupation			any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize					
Employer/School Address				the use of my signature on all insurance submissions.				
			1		ist may use my health care information a	•		
Employer/School Phone			such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits					
Spouse's Name			or the benefits payable for related services. This consent will end when my					
Birthdate				current treatment plan is completed or one year from the date signed below.				
SS#			Signature of Patient, Parent, Guardian or Personal Representative					
Spouse's Employer				Please print name of Patient, Parent, Guardian or Personal Representative				
Whom may we thank for referring you?				Date Relationship to Patient				
					. Control of the cont			
Phone Numbers								
Home ()	V	Vork ()		Ext	Cell Phone ()			
Spouse's Work ()	B	sest time and place to rea	ach you _					
IN CASE OF EMERGENCY, CO	ONTACT (Spe	cify someone who does	not live in	your housel	hold.)			
Name			Relati	onship				
Home Phone ()			Work Phone ()					
\ <u></u> /								
Dental History								
Reason for today's visit		Burning sensation on to	naue	☐ Yes ☐ No	Mouth breathing	□Yes □No		
		Chew on one side of mouth		☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐No		
Former Dentist				☐ Yes ☐ No	Orthodontic treatment	☐Yes ☐No		
City/State		Clicking or popping jaw		☐ Yes ☐ No	Pain around ear	☐Yes ☐No		
Date of last dental visit		Dry mouth		☐ Yes ☐ No	Periodontal treatment	☐Yes ☐No		
Date of last dental X-rays		Fingernail biting Food collection between	the teeth	☐ Yes ☐ No	Sensitivity to cold Sensitivity to heat	☐Yes ☐No		
,		Foreign objects		☐ Yes ☐ No	Sensitivity to sweets	□Yes □No □Yes □No		
Place a mark on "yes" or "no" to indicate if you have had any of the following:		Grinding teeth		☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐No		
-		Gums swollen or tender		□Yes□No	Sores or growths in your mouth	☐Yes ☐No		
Bad breath	□Yes □No	Jaw pain or tiredness		☐ Yes ☐ No	How often do you floss?			
Bleeding gums Blister on lip or mouth	□Yes □No □Yes □No	Lip or cheek biting	llings	☐ Yes ☐ No	•			
Photor on the or modern		Loose teeth or broken fil	iii iyə	☐ Yes ☐ No	How often do you brush?			

Dental History									
Physician's Name			Date of last visit						
Place a mark on "yes" or "no" to indicate if you have had any of the following:									
AIDS/HIV Anemia Arthritis, Rheumatism Artificial Heart Valve Artificial Joints Asthma Back Problems Bleeding abnormally, with extractions or surgery Blood Disease Cancer Chemical Dependency Chemotherapy Circulatory Problems Congenital Heart Lesions Cortisone Treatments Cough, persistent or bloody Diabetes Emphysema Do you wear contact lenses?	Yes No Yes Yes	Epilepsy Fainting or dizziness Glaucoma Headaches Heart Murmur Heart Problems Hepatitis Type Herpes High Blood Pressure Jaundice Jaw Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Problems Nervous Problems Pacemaker Psychiatric Care Radiation Treatment	Yes No Yes Y	Respiratory Disease Rheumatic Fever Scarlet Fever Shortness of Breath Sinus Trouble Skin Rash Special Diet Stroke Swollen Feet or Ankles Swollen Neck Glands Thyroid Problems Tonsillitis Tuberculosis Tumor or growth on head or neck Ulcer Venereal Disease Weight Loss, unexplained	YesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNoYesNo				
Women: Are you pregnant? ☐ Yes ☐ No Taking birth control pills? ☐ Ye		9	Are you nu	rsing? □ Yes □No					
Medications			Allerg	ies					
List any medications you are currently taking and the correlating diagnosis: Pharmacy Name Phone ()			□ Aspirin □ Local Anesthetic □ Barbiturates (Sleeping pills) □ Penicillin □ Codeine □ Sulfa □ Iodine □ Other □ Latex						
Updates (To be fill	led in at future	appointments)							