

PATIENT DENTAL HISTORY

Do your gums bleed while brushing or flossing? Yes No	Do you have frequent headaches? Yes No
Are your teeth sensitive to hot or cold liquids/foods? Yes No	Do you clench or grind your teeth? Yes No
Are your teeth sensitive to sweet or sour liquids/foods? Yes No	Have you ever had any complications following dental treatment? Yes No If yes, please explain
Do you feel pain in any of your teeth? Yes No	Do you wear dentures or partials? Yes No If yes, date of placement
Do you have any sores or lumps in or near your mouth? Yes No	Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
Have you had any head, neck, or jaw injuries? Yes No	Do you like your smile? Yes No
Have you ever experienced any of the following problems in your jaw? Clicking Yes No	If No, what would you change?
Pain (joint, ear, side of face) Yes No	
Difficulty in opening or closing Yes No	

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to patient: _____

Address: _____

Street City Zip Code

Circle appropriate: Single Married Gender: Male/Female

SS#: _____ DL#: _____ Date of Birth: _____

Phone: Home _____ Work _____ Ext _____ Cell _____

Employer: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Is insured a patient? YES NO

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Insured's Date of Birth: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer: _____ Phone: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Is insured a patient? YES NO

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Insured's Date of Birth: _____ ID #: _____ Group #: _____

Insured's Address: _____

Insured's Employer: _____ Phone: _____

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 payers 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 usual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date 3/06

Signature of patient (or Parent/Guardian if minor)

Date

3/06