

PATIENT INFORMATION

| | | | |
|----------------------------|-------------|------------------------|--|
| Name (Last, First, Middle) | | Social Security Number | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address | City | State | ZIP |
| Phone Number(s): Home | Cellular | Work | Email Address |
| Date of Birth | Birth Place | Status | <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED / SEPARATED |
| Occupation | Employer | Years Employed | |

PARENT OR GUARDIAN OF PATIENT (IF PATIENT IS UNDER 18 YEARS OF AGE)

| | | | |
|----------------------------|-------------|------------------------|--|
| Name (Last, First, Middle) | | Social Security Number | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address | City | State | ZIP |
| Phone Number(s): Home | Cellular | Work | Email Address |
| Date of Birth | Birth Place | Status | <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED / SEPARATED |
| Occupation | Employer | Years Employed | |

INSURANCE INFORMATION

| | | | |
|---|---------------------------|-------------------------|--------------------------------------|
| Subscriber's Name (Last, First, Middle) | | Date of Birth | Social Security or Subscriber's I.D. |
| Name of Insurance Company | Insurance Company Address | | Group / Plan Number |
| Employer's Name | Employer's Phone Number | Relationship To Patient | |

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

| | | | |
|---|---------------------------|-------------------------|--------------------------------------|
| Subscriber's Name (Last, First, Middle) | | Date of Birth | Social Security or Subscriber's I.D. |
| Name of Insurance Company | Insurance Company Address | | Group / Plan Number |
| Employer's Name | Employer's Phone Number | Relationship To Patient | |

PERSON RESPONSIBLE FOR ACCOUNT

| | | | |
|----------------------------|-------------------------|------------------------|---|
| Name (Last, First, Middle) | | Social Security Number | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address | City | State | ZIP |
| Phone Number(s): Home | Cellular | Work | Email Address |
| Date of Birth | Relationship To Patient | | |

GETTING TO KNOW YOU

- Why did you select our office? _____
- Whom may we thank for referring you? Yellow Pages Website/Internet Patient: _____
 Other: _____
- Is another member of your family or relative a patient in our practice? YES NO
- Person to contact in case of emergency: _____ Relationship: _____
Contact Phone Number(s): _____
Home Cellular Work Pager

PATIENT INFORMATION

Name: _____ Date: _____

What is your immediate concern? _____

TOOTH STRUCTURE

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you feel pain or discomfort in any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids or foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to biting pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are your teeth sensitive to sweets or sour foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are there places where food always seems to get caught? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you lost any teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had any cavities within the last three years? | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you or have you ever smoked or chewed tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had periodontal (gum) treatment? When? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have an unpleasant taste or odor in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is there a family history of gum problems? | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you grind or clench your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Can you chew gum comfortably? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Can you eat a bagel comfortably? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel like you have more than one bite? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have your teeth changed, become shorter, thinner, or worn? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had jaw joint pain, clicking, or popping? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had orthodontic treatment? When? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE ASSESSMENT

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you like to smile wide enough to show your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Would you change anything with the way your teeth look? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever whitened (bleached) your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been disappointed by the appearance of previous work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you interested in improving the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Would you like to learn more about modern cosmetic procedures? | <input type="checkbox"/> | <input type="checkbox"/> |

PERSONAL HISTORY

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How fearful on a scale of 1(least) to 10(most)? | | |
| 3. Have you ever had an unfavorable dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a complication from dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had trouble getting numb or had reactions to shots? | <input type="checkbox"/> | <input type="checkbox"/> |

GOAL

The major objective of our office is to provide our patients with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel any misunderstandings can be minimized if financial policies are agreed upon at the beginning of treatment. The following information is to acquaint you with our financial policies.

PATIENTS WITH DENTAL INSURANCE

As a courtesy to our patients with insurance, we will bill their insurance provider for them at time of service. Our office will accept assignment of benefits from your insurance company, which allows them to send payment directly to us rather than having you pay for your services in full at time of service. Our office will estimate the portion of the services not covered by your insurance, either due to policy information and/or patient copayment percentages. This estimated patient portion is due at time of service; should your insurance pay more than we anticipate, we will promptly reimburse you.

PATIENTS WITHOUT DENTAL INSURANCE

All fees for services are due at time of service.

ALL PATIENTS

Our office accepts cash, check, Mastercard, and Visa. Our office also offers, to patients who would like to make monthly payments, an option to provide third party financing through Citi Health Card. If you are interested in utilizing the Citi Health Card payment plan option, please ask our staff.

Patient Name (*please print*)

Patient Signature

Date