WELCOME

The Studio for Exceptional Dentistry

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____

Patient's Date of Birth: _____

Patient's Address: _____

Patient's Social Security #: _____

_____

Patient's Phone #: _____

_____

Cell Phone #: _____

Patient's Age: _____ Sex: _____

Marital Status: _____

How did you hear about our office? _____

Email Address: _____

May we contact you for appointment reminders by email: YES NO (circle one) or text message: YES NO (circle one)

RESPONSIBLE PARTY

Responsible Party: _____

Date of Birth: _____

Address: _____

Social Security #: _____

_____

Phone#: _____

_____

Cell Phone #: _____

Relationship to Patient: _____

Work Phone #: _____

THE STUDIO FOR EXCEPTIONAL DENTISTRY

INSURANCE INFORMATION

Name of Insured: _____

Relationship to Patient: _____

Address: _____

Date of Birth: _____

_____

Social Security #: _____

Employer: _____

Phone: _____

Address: _____

Group #: _____

_____

Member #:_____

Insurance Company: _____

Phone #: _____

Family/Single Coverage: _____

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____

What is your reason for seeking care at this time: _____

Do you have regular dental checkups? When was your last dental exam: _____

Do you have any pain or discomfort now? What: _____

Do your gums bleed? _____ Have you had surgery preformed on your gums? _____

Have you ever had a root canal? _____ Have you ever worn braces? _____ Do you have frequent headaches? _____

Do you clinch/grind your teeth?_____ Have you ever had any trauma to your face or mouth? _____

Do you floss? How often _____ How many times a day do you brush your teeth? _____

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 also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

THE STUDIO
FOR EXCEPTIONAL DENTISTRY

_____ Date: _____

Signature of Patient/Parent or Guardian