Excellence In Dentistry

Patient Information

Name: _____ Age: _____ Birth Date: _____

Sex: Male ☐ Female ☐ Soc. Sec. #: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City/State/Zip: _____

Email: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____ Employer: _____ Work Phone: _____

In case of emergency, notify: _____ Relationship: _____

Phone Number: _____ Address/City/State/Zip: _____

Whom may we thank for referring you? _____

Former Dentist: _____ Address/City/State/Zip: _____ Phone: _____

Date of last dental care: _____ Date of last full mouth x-rays: _____

How often do you brush: _____ Floss: _____ How do you feel about your teeth? _____

Check if you have had problems with any of the following:

☐ Bad breath ☐ Food collection between teeth ☐ Periodontal treatment ☐ Sensitivity to sweets

☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Sensitivity when biting

☐ Sensitivity to cold ☐ Sensitivity to hot ☐ Sores or growths in mouth

Who are we allowed to discuss your treatment with?

Name: _____ Relation: _____ Phone Number: _____

Primary Dental Insurance

Insurance Company: _____ Phone: _____ Group #: _____

Subscriber Name: _____ Relation to patient: _____ Birth Date: _____

Sex: Male ☐ Female ☐ Soc. Sec. #: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City/State/Zip: _____

Occupation: _____ Employer: _____ Work Phone: _____

Additional Dental Insurance

Insurance Company: _____ Phone: _____ Group #: _____

Subscriber Name: _____ Relation to patient: _____ Birth Date: _____

Sex: Male ☐ Female ☐ Soc. Sec. #: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City/State/Zip: _____

Occupation: _____ Employer: _____ Work Phone: _____

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs and authorized their use in lectures/publications. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself, my dependents, or the patient named above is mine, due and payable at time of service. I also agree that I shall pay all costs incurred in collecting past due amounts (of more than 60 days) including reasonable attorneys fees. I further understand that a finance charge of 24% annually will be added to any overdue balance, a late fee may be added if my payment is late, and charges may be added for broken appointments. I also assign all insurance benefits to the Doctor.

Signature: _____ Date: _____

IF CONSENT IS GIVEN BY A PARENT/GUARDIAN, THE FOLLOWING INFORMATION IS REQUIRED:

Print: Name: _____ Birth Date: _____

Sex: Male ☐ Female ☐ Soc. Sec. #: _____ Employer: _____

(If different than patient)

Home Phone: _____ Cell Phone: _____

Address: _____ City/State/Zip: _____