- contill and		attiputiti.			
Patient Information		Dental	Insurance		
Date		Who is responsible for this account?			
SS/HIC/Patient ID #		Relationship to Patient			
		Insurance Co			
Patient NameLast Name		Group #			
First Name Middle Initial		Is patient covered by additional insurance?   Yes   No			
Address		Subscriber's Name			
E-mail					
		Birthdate SS#			
City		elationship to Patie	nt		
StateZip		Insurance Co.			
Sex M F Age		Group #			
			ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with		
☐ Married ☐ Widowed ☐ Single	☐ Minor	certify that I, and/			
☐ Separated ☐ Divorced ☐ Partnered for years		Name of Insurance Company(ies) and assign directly to			
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.			
			ist may use my health care information above-named Insurance Company(ies)		
Employer/School Phone ()	l the	e purpose of obtaining	g payment for services and determining for related services. This consent will e	g insurance benefits	
Spouse's Name	tre		eted or one year from the date signed by		
[ # 전 - 이토양 그런데 뭐 - 중요한 글랜드 10 1		Signature of Pat	ient, Parent, Guardian or Personal Rep	rocontativo	
Birthdate		Signature of Fat	ieni, raieni, dualulan oi reisonal nep	resemanve	
SS#		Please print name of	Patient, Parent, Guardian or Personal	Representative	
Spouse's Employer		B-1-	Distriction		
Whom may we thank for referring you?		Date	Relationship t	.o Patient	
Phone Numbers				•	
	Work (		Alt. Phone (		
	Work ()	Ext			
Spouse's Work () IN CASE OF EMERGENCY, CONTACT (Specify s					
Name					
Phone ()	All. I	Phone ()			
Dental History		10 m			
Reason for today's visit	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	
	Chew on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No	
Former Dentist	Cigarette, pipe, or cigar smokir	ng 🗌 Yes 🔲 No	Orthodontic treatment	☐ Yes ☐ No	
	Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No	
City/State	Dry mouth Fingernail biting	☐ Yes ☐ No	Periodontal treatment Sensitivity to cold	☐ Yes ☐ No ☐ Yes ☐ No	
Date of last dental visit	Food collection between the tee	th Yes No	Sensitivity to heat	☐ Yes ☐ No	
Date of last dental X-rays	Foreign objects	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No	
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Grinding teeth Gums swollen or tender	☐ Yes ☐ No	Sensitivity when biting 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 Yes No	Lip or cheek biting	☐ Yes ☐ No			
Blisters on lips or mouth ☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush?		

**Dental Registration and History**