AD DENTISTRY

Patient Information:

□ Deaf?

First Name: _____ Last Name: _____ Home Phone: _____ □ VP?

Address: _____ Apt. No. _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SSN: _____ DOB:_____ E-Mail:_____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Are any of your family members patients of this practice? □ No □ Yes, Name: _____

If the person responsible for the account is different than the patient detailed above, please fill in this section:

Name: _____ Relationship: _____ Phone: _____

Address: _____ Apt. No. _____

City: _____ State:_____ Zip: _____ E-Mail: _____

Name of Primary Dental Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ ID #: _____

Employer: _____

Group #: _____

Name of Secondary Dental Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ ID #: _____

Employer: _____

Group #: _____

Dental History

What is the reason for this appointment? _____

Are there any specific dental problems we should be aware of? _____

What was the purpose of your last dental appointment? _____ When? _____

When was the last time you had a dental cleaning? _____ Name of previous dentist: _____

When was the last time you had dental x-rays? _____ Why? Which teeth? _____

How would you describe your dental health? □ Excellent □ Good □ Fair □ Poor

Do you think you have decay or cavities? □ Yes □ No How often do you brush? _____

Do you suffer from chronic bad breath or bad taste? □ Yes □ No How often do you floss? _____

Do you have any jaw joint cracking or pain? □ Yes □ No

Whom may we thank for referring you to our office? _____

Patient Treatment Consent

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes this practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records, x-rays, and other information deemed pertinent to my insurance carrier as necessary and/or requested. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge.

Patient/Parent or Guardian Signature_____ Date: _____