

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: _____ Age: _____ M S D W
 Home Address: _____ City: _____ State: _____ Zip: _____
 Home Phone#: _____ Cell Phone#: _____ Email: _____
 SS#: _____ Employer/Occupation: _____ Work Phone#: _____
 Spouse/Both Parents Name: _____ Daytime Phone#: _____
 Emergency contact: _____ Relationship: _____ Daytime Phone#: _____
 Medical Dr: _____ Last visit: _____ Previous Dentist: _____ Last Visit: _____
 Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Person responsible for account: _____ Relationship: _____ Work & Home Phone#: _____
 Address: _____ City: _____ State: _____ Zip: _____ SS#: _____

INSURANCE INFORMATION

Subscribers Name: _____ DOB: _____ SS#: _____
 Work & Home Phone#: _____ Subscribers Employer: _____
 Dental Insurance Co: _____ Ins. Co. Address: _____
 Ins. Co. Phone#: _____ Group# _____ Relationship to Patient: _____

SECONDARY INFORMATION

Subscribers Name: _____ DOB: _____ SS#: _____
 Work & Home Phone#: _____ Subscribers Employer: _____
 Dental Insurance Co: _____ Ins. Co. Address: _____
 Ins. Co. Phone#: _____ Group# _____ Relationship to Patient: _____

DENTAL HEALTH HISTORY

Are you apprehensive about dental treatment	y	n
Have you had problems with previous dental treatment?	y	n
Do you gag easily?	y	n
Do you wear dentures?	y	n
Does food catch between your teeth?	y	n
Do you have difficulty in chewing your food?	y	n
Do you have difficulty in chewing your food?	y	n
Do you chew on only one side of your mouth?	y	n
Do you avoid brushing any part of your mouth because of pain?	y	n
Do your gums bleed easily?	y	n
Do your gums bleed when you floss?	y	n
Do your gums feel swollen or tender?	y	n
Have you ever noticed slow-healing sores in or about your mouth?	y	n
Are your teeth sensitive to hot, cold, sweets?	y	n
Do you take fluoride supplements	y	n
If you could change something about your smile what would it be?		
Do you prefer to save your teeth?	y	n
Do you want complete dental care?	y	n
How often do you brush?		
How often do you floss?		
Does it hurt when you chew or open wide to take a bite?	y	n
Do you have any jaw symptoms or headaches?	y	n
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	y	n

Method of Payment

Does the responsible party have an account with this office?

Yes No

- Payment in full at each appointment (cash or personal check)
- Payment in full at each appointment (Visa MC Other)
- I wish to discuss the office's financial policy

Authorization

I hereby authorize payment directly to Spearfish Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Spearfish Family Dentistry to administer such diagnostic, photographic and therapeutic procedures as may be necessary for my complete dental care. The information on this page and on the medical/dental histories page are correct to the best of my knowledge. I grant the right to the dentist to release my medical/dental treatment to third party payors and/or other authorized health professionals.

X

Patient/Responsible Party

Date