Patient Employer/School	SS/HIC/Patient ID #		Who is resp	ible for	this account?	
Relationship to Patient Description De	SS/HIC/Patient ID #			onsible lor	this accountr	
Insurance Co. Group # Insurance Co. Insura			Relationship	to Patient		
First Name	Patient Name		Insurance C	0		
Subscriber's Name Birthdate	Last Name		Group #			
Birthdate	First Name	Middle Initial	Is patient co	vered by a	additional insurance? Yes	□ No
Birthdate	Address	Subscriber's Name				
Relationship to Patient Insurance Co. Group # Age Gr		Birthdate SS#				
Insurance Co. Group # Age Ag						
Group #						
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Patient Employer/School			I certify that	I, and/or	my dependent(s), have insurar	nce coverage with
Patient Employer/School Dr. all insurance benefit any, otherwise payable to me for services rendered. I understand that I manually responsible for all charges whether or not paid by insurance authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may discide the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may discide the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may discide the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may discide the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may discide authorize the use of my signature on all insurance benefit or problem to paid the problems. The above-named dentist may use my health care information and may discide authorize the use of my signature on all insurance benefit or paid to problems. The above-named dentist may use my health care information and may discident authorize the use of my signature on all insurance benefits may use my health care information and may discident authorize the use of my signature on all insurance benefits may use my health care information and may discident authorize the use of my signature on all insurance authorizes the use of my signature on all insurance benefits may use my health care information and may discident authorize the use of my signature on all insurance benefits may use my health care information and may discident the relation authorize the use of prelimity and paid insurance company (is and the flag of the flag of the flag of the propose of obtaining payment for services and determining insurance company files and the flag of the flag of the propose of obtaining payment for all dentities of the flag o	Separated Divorced Partnered	for years		ame of lac-		nd assign directly to
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The above-named dentist may use my health care information and may discit such information to the above-named insurance Company(ies) and their age for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end with my current treatment plan is completed or one year from the date signed belt signature of Patient, Parent, Guardian or Personal Representative SS# Spouse's Employer Whom may we thank for referring you? Phone Numbers Phone (Employer/School Address	financially re	sponsible fo	or all charges whether or not pa	aid by insurance. I	
Employer/School Phone () Spouse's Name						
Spouse's Name	Employer/School Phone ()		such informat	tion to the at	pove-named Insurance Company(in	es) and their agents
Signature of Patient, Parent, Guardian or Personal Representative	Spouse's Name		benefits or th	e benefits pa	ayable for related services. This co	nsent will end when
SS# Signature of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient						
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Best time and place to reach you IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) Name						
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City/State	hone ()	B. THE SER	Work Pho	ne ()	
Chew on one side of mouth		Dontal	Histor.			
Cigarette, pipe, or cigar smoking Yes No Orthodontic treatment Yes City/State Dry mouth Yes No Orthodontic treatment Yes Date of last dental X-rays Foreign objects Yes No Periodontal treatment Yes No Sensitivity to cold Yes No Sensitivity to sweets Yes No Sensitivity when biting Yes	Reason for today's visit			The second second	Mouth breathing	□Yes □No
smoking Yes No Orthodontic treatment Yes Clicking or popping jaw Yes No Pain around ear Yes Date of last dental X-rays Foreign objects Yes No Pain around ear Yes Date of last dental X-rays Foreign objects Yes No Sensitivity to cold Yes Date of last dental X-rays Foreign objects Yes No Sensitivity to sweets Yes Date of last dental X-rays Sensitivity to sweets Yes Date of last dental X-rays Sensitivity to sweets Yes Date of last dental X-rays No Sensitivity to sweets Yes No Sensitivity to sweets Yes No Sensitivity to sweets Yes No Sensitivity t	Todason for today a visit			3 LINO	and the second s	The same of the same of
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Place a mark on "yes" or "no" to indicate if you have had any of the following: Food collection between the teeth						
Date of last dental X-rays the teeth Yes No Sensitivity to sweets Yes Place a mark on "yes" or "no" to indicate if Foreign objects Yes No You have had any of the following: Grinding teeth Yes No Sores or growths in your			en		CONTRACTOR OF CONTRACTOR	Yes No
you have had any of the following: Grinding teeth Sores or growths in your						
Sores or growths in your						☐ Yes ☐ No
Bad breath	ad breath Yes No	Gums swollen or tend				☐ Yes ☐ No
Bleeding gums	leeding gums	Jaw pain or tiredness	□ Ye	s 🗆 No		E 103 E 110