

EMERGENCY INFORMATION

Spouse's Name _____ Birth Date ____/____/____

Spouse's Occupation _____ Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT (Specifically someone not living in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Dental Insurance Co. _____

Dental Insurance Co. _____

Policyholder's Name _____

Policyholder's Name _____

Policyholder's Birth Date _____

Policyholder's Birth Date _____

Group Number _____

Group Number _____

I.D. # or SS # _____

I.D. # or SS # _____

Patient Relationship to Policyholder _____

Patient Relationship to Policyholder _____

DENTAL HISTORY TO BE FILLED OUT BY NEW PATIENTS ONLY

Reason for Today's Visit _____

Have you ever had any problems with any of the following?

Y N Bad breath

Y N Food collecting in teeth

Y N Periodontal treatment

Y N Bleeding gums

Y N Grinding teeth

Y N Sensitive to cold

Y N Blister on lips or mouth

Y N Jaw pain

Y N Sensitive to hot

Y N Clicking or popping jaw

Y N Loose teeth/ broken filling

Y N Sensitive to sweets

Y N Dry mouth

Y N Orthodontic treatment

Y N Sore or growths in your mouth

How often so you floss? _____ How often do you brush? _____

Authorization

Patients who carry Dental Insurance are reminded that professional services are rendered and charged to the patient, not the insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of dental information to my insurance company and request the Dentist process my insurance claims. I assign and authorize benefits to be paid directly to the dentist. I am aware that fees not paid in full at time of service are billed through First Pacific Corporation and I have read and signed the truth in lending statement of the following page. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Name _____ Date _____