## WELCOME TO OUR DENTAL PRACTICE

**PATIENT INFORMATION**

Name: _____ Preferred Name: _____ Driver's Lic. #: _____

Address: _____ (STREET) _____ (CITY/STATE/ZIP)

Employer: _____ Occupation: _____

Work Address: _____ (STREET) _____ (CITY/STATE/ZIP) Work Phone: _____

Home Phone: _____ Cell Phone: _____ May we call you at work? ☐ Yes ☐ No

Social Security #: _____ Birthdate: _____ Sex: M / F Marital Status: _____

E-Mail Address: _____ Do you regularly check your email? _____

How did you hear about our practice? _____ Do you accept text messaging? ☐ Yes ☐ No

**PERSON RESPONSIBLE FOR PAYMENT OR ACCOUNT** ☐ **SAME AS PATIENT**

Name: _____ Relationship to patient: _____

Home Address: _____ (STREET) _____ (CITY/STATE/ZIP)

Employer: _____ Occupation: _____

Work Address: _____ (STREET) _____ (CITY/STATE/ZIP) Work Phone: _____

Home Phone: _____ Cell Phone: _____ May we call you at work? ☐ Yes ☐ No

Social Security #: _____ Birthdate: _____ Driver's Lic. #: _____

E-Mail Address: _____ Sex: _____ Marital Status: _____

**IS THERE ANYONE ELSE RESPONSIBLE FOR THIS PATIENT'S ACCOUNT?** ☐ **NO** ☐ **YES, Fill Out Lines Below**

Name: _____ Relationship to patient: _____

Home Address: _____ (STREET) _____ (CITY/STATE/ZIP) Work Phone: _____

Home Phone: _____ Cell Phone: _____ May we call you at work? ☐ Yes ☐ No

Social Security #: _____ Birthdate: _____ Driver's Lic. #: _____

**DENTAL INSURANCE INFORMATION**

Primary Insurance Company: _____

Group #: _____

Employer: _____

Subscriber's Name: _____

Relationship to patient: _____

Subscriber Social Security or ID #: _____ DOB _____

Union or Local #: _____

**SECONDARY INSURANCE INFORMATION**

Primary Insurance Company: _____

Group #: _____

Employer: _____

Subscriber's Name: _____

Relationship to patient: _____

Subscriber Social Security or ID #: _____ DOB _____

Union or Local #: _____

Name of school if patient is a student: _____

**Emergency Contact:** _____ **Phone Number(s):** _____

DeSoto Family Dental Care treats patients based on their dental needs and does not make recommendations based on dental insurance companies. I understand that I am financially responsible for payment of all charges, including charges in excess of my insurance reasonable and customary. I authorize my insurance benefits directly to DeSoto Family Dental Care. I understand that I am responsible for verifying my insurance coverage and understanding the benefits that I have. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original. Additionally, I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

The information given today is correct and to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status, medications, and insurance benefits.

Signature: _____ Date: _____

(OVER PLEASE)

**Please check any of the following that apply to you:**

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain/discomfort when chewing
- ☐ Headaches
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Teeth or fillings breaking
- ☐ Bad breath or bad taste in mouth
- ☐ Jaw Joint Pain
- ☐ Dry Mouth

**If you could change your teeth/smile, you would:**

- ☐ Make it brighter, whiter
- ☐ Make your teeth straighter
- ☐ Close spaces
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover
- ☐ Replace black metal fillings with natural ones

**Do you have or have you had any of the following:**

- ☐ Dentures
- ☐ Implants
- ☐ Braces
- ☐ Peridontal Disease
- ☐ Partial Dentures
- ☐ Fear/Anxiety of Dental Procedures

**Please share the following dates:**

Your last cleaning _____/ _____

Your last complete X-rays _____/ _____

Your last oral cancer screening _____/ _____

**On a scale of 1 - 10, with 10 being the highest rating:**

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

***So that we may best meet your needs, please let us know if you have had any problems/concerns in the past at a dental office:***

_____

_____