SILOAM SMILES

PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

SS #: _____

Home Phone ( ) _____

Cell Phone ( ) _____

Work Phone ( ) _____

Email: _____

Sex □ M □ F Age: _____

Birthdate:

□Married □Widowed □Single

□Separated □Divorced □Minor

Occupation: _____

Employer Name: _____

Employer Address: _____

Work Phone: _____

Spouse Name: _____

Birthdate: _____

SS #: _____

Spouse Employer: _____

Spouse Work Phone: ( ) _____

IN CASE OF EMERGENCY

Name: _____

Relationship: _____

Phone: _____

DENTAL INSURANCE

Responsible Party for Account _____

Relationship to Patient _____

Insurance Company _____

Group #/ID# _____

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Is there additional coverage for patient? □ YES □NO

Secondary Insurance _____

Group #/ID # _____

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

ASSIGNMENT & RELEASE

I certify that I and/or any dependent, have insurance coverage with _____ and assign directly to Siloam Smiles all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Siloam Smiles may use my health care information and may disclose due information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient or Guarantor

_____

Please print name of Patient or Guarantor

_____ _____

Date Relationship to Patient

DENTAL HISTORY

Former Dentist _____

City/State _____

Date of last cleaning _____

Date of last dental x-rays _____

Check if you have or have had any of the following:

□ Bad breath
□ Bleeding gums
□ Tender/swollen gums
□ Loose Teeth
□ Perio (Gum) treatment
□ Broken fillings
□ Sores or growths
□ Orthodontics (Braces)
□ Grinding teeth
□ Cold sensitivity
□ Host sensitivity
□ Sweet sensitivity
□ Pressure sensitivity
□ Food collecting
□ Dry mouth
□ Clicking/popping jaws

How often do you brush?

How often do you floss?

ADDITIONAL INFORMATION

Reason For Today's Visit _____

On a scale of 1-5 (5 being the highest), please rank the following in order which they would keep you from having dental treatment:

Fear of Pain _____

Lack of Concern _____

Cost of Treatment _____

Missing Work _____

Whom may we thank for referring you?

_____

Please list family members that come to our office.

_____