WELCOME

PATIENT INFORMATION | DENTAL INSURANCE

Relationship to Patient	17 11 11 11 11 11	014.11		. 1 1 1 1 1 1	114701014114		
Insurance Co. Grup # Issurance Co. Gru	Date			Who is responsible for this account?			
Address Size	SS/HIC/Patient ID #		Relati	ionship to Patie	nt		
Address Size	Patient		Insura	ance Co.			
State							
Birthdate	City						
Birthdate	State	7in	Subso	criber's Name_			
Relationship to Patient				BirthdateSS#			
Insurance Co. Group # ASSIGNMENT AND RELEASE certify that 1, and/or my dependent(s), have insurance coverage will and assign directly to Name of Insurance Company(tes) and assign directly to Name of Insurance Company(tes) Name of Insurance Company(tes) Name of Insurance Demployer/School Address certify that 1, and/or my dependent(s), have insurance coverage will and assign directly to Name of Insurance Company(tes) Name of Insurance Company(tes) Name of Insurance Company(tes) Name of Insurance Submissions. Name of Insurance Submissions. Name of Insurance Submissions Name of			Relati	ionship to Patie	nt		
Group # ASSIMISHT AND RELEASE cerify that I, and/or my dependent(s), have insurance coverage will insurance the insurance coverage will insurance company(ies) and assign directly to name of Insurance Company(ies) and insurance benefits, and, other insurance submissions. The above-named footor may use my health care information and may discuss the information to the above-named footor may use my health care information and may dead the the benefits payable for related services. Information and may dead such information to the above-named footor may use my health care information and may dead the the benefits payable for related services. Information and may dead the benefits payable for related services. Information and may dead the benefits payable for related services. Information and may dead the benefits payable for related services. Information and may dead the payable of the benefits and the payable of the benefits and the information and may dead the payable of the benefits and the payable of the benefits and the payable of the benefits and the payable of the payable of the benefits and the payable of the payab	Birthdate			Insurance Co.			
Married Widowed Single Minor SaskinMetra AND RELEASE Certify that I, and/or my dependent(s), have insurance coverage with partial properties of the propose of obtaining payment for services rendered. I understend that I am financial responsible for all charges whether or not pide by insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named descripe such information to the above-named descripe apprenent for services. This consent will end when my currer treatment plan is completed or one year from the date signed below. Signature of Patient, Parent, Guardian or Personal Representative the purpose of obtaining payment for services. This consent will end when my currer treatment plan is completed or one year from the date signed below. PHONE NUMBERS Home (Group #			
Separated Divorced Partnered foryears	☐ Married ☐ Widowed ☐ Single ☐ Minor			ASSIGNMENT AND RELEASE			
Name of Insurance Company(ies)	☐ Separated ☐ Divorced	☐ Partnere		ity that I, and/			
Patient Employer/School Burning sensation on tongue Yes No Mouth prainting Yes No Mouth p	Occupation			Name of I	nsurance Company(ies)	d assign directly to	
any, otherwise payable to me for services rendered. I understand that I am financial corresponsible for all changes whether or pail by insurvance. I authorize the use or my signature on all insurvance submissions. The above-named incurance Submissions. The above-named doctor may use my health care information and may disable such information to the above-named incurance Company(se) and their agents to the benefits payable for related services. This consent will and when my currer treatment plan is completed or one year from the date signed below. SS# Spouse's Employer Whom may we thank for referring you? PHONE NUMBER\$ Home () Best time and place to reach you IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) Name Home Phone () PENTAL HISTORY Reason for today's visit					all in	surance benefits, i	
my signature on all insurance submissions. The above-named doctor may use my health care information and may discloss use information to the above-named insurance Company(les) and their agents to the propose of obtaining payment for services and determining insurance benefits of the benefits peable for related revises. This consenser will end when my currer treatment plan is completed or one year from the date signed below. Birthdate SS# Spouse's Employer Whom may we thank for referring you? Please print name of Patient, Parent, Guardian or Personal Representative Whom may we thank for referring you? Please print name of Patient, Parent, Guardian or Personal Representative Work (roopon		o me for services rendered. I understand	that I am financially	
such information to the above-named insurance Company(les) and their agents to the purpose of obtaining part for services and determining insurance benefits the purpose of obtaining part for services and determining insurance benefits the purpose of obtaining part for services and determining insurance benefits the purpose of obtaining part for services. This consent will end when my currer treatment plan is completed or one year from the date signed below. Signature of Patient, Parent, Guardian or Personal Representative	Employer/School Address						
Employer/School Phone (
Spouse's Name	Employer/School Phone ()Spouse's Name			the purpose of obtaining payment for services and determining insurance benefits on the benefits payable for related services. This consent will end when my current the benefits payable for related services.			
Signature of Patient, Parent, Guardian or Personal Representative							
SS#							
Please print name of Patient, Parent, Guardian or Personal Representative				Signature of Pa	tient, Parent, Guardian or Personal Rep	presentative	
Whom may we thank for referring you? Date Relationship to Patient				aana ariist sama	of Patient Payent Cuardian as Payenal	Demuse autotive	
PHONE NUMBERS Home ()				ease print name o	or Patient, Parent, Guardian or Personal	Hepresentative	
Home (Whom may we thank for referring	g you?		Date	Relationship t	o Patient	
Home (PHONE NVM	BERS					
Spouse's Work (Work (Evt	Cell Phone (
Name							
Name							
Burning sensation on tongue							
DENTAL HISTORY Burning sensation on tongue							
Burning sensation on tongue	nome Priorie ()		VVOIK	CPHONE (_),		
Chew on one side of mouth	DENTAL HIST	ORY					
City/State	Reason for today's visit		Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	
Former Dentist Clicking or popping jaw			Chew on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No	
City/State	Former Dentist						
Fingernail biting	Olic						
Date of last dental visit	Date of last dental visit Date of last dental X-rays		일반(전투일) [2] [4] 보고 [2] [2] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4				
Place a mark on "yes" or "no" to indicate if you							
have had any of the following: Gums swollen or tender Yes No Sores or growths in your mouth Yes No Bleeding gums Gums swollen or tender Yes No How often do you floss? Yes No No Sores or growths in your mouth Yes No Bleeding gums			Foreign objects				
Bad breath	Place a mark on "yes" or "no" to indicate if you						
Bleeding gums		□ Ves □ Ne				∐ Yes ∐ No	
사용하다는 전문에 있는데 이번에 가장되었다면 하면					110W Offerr do you 11033:		