OBEIDDENTAL

Patient Information

Name (Last, First Middle): ______________________________

Date of Birth: ______________ Social Security #: ______________ Gender: ___ Male ___ Female

Address: ______________________________

Work Phone: ______________ Home Phone: ______________ Cell Phone: ______________

Email Address: ______________ Drivers License Number: ______________ Issuing State: _________

Employer & Address: ______________________________

Emergency Contact: ______________ Contact Phone: ______________

Whom may we thank for referring you to our office? ______________________________

Responsible Party Information (if different from patient):

Name (Last, First Middle): ______________________________

Date of Birth: ______________ Social Security #: ______________ Gender: ___ Male ___ Female

Address: ______________________________

Work Phone: ______________ Home Phone: ______________ Cell Phone: ______________

Relationship to Patient: ______________________________

Dental Insurance Information:

Primary Insurance Company: ______________________________

Policy #: ______________ Group #: ______________

Dental History:

How is your dental health? Excellent Good Fair Poor Reason for this appointment: ______________

Any specific dental problems we should be aware of: ______________________________

Name of previous dentists: ______________________________

Purpose of your last dental appointment: ______________ When was that? ______________

When was the last time you had a dental cleaning? ______________ Dental x-rays?______________

How often do you brush? ______________ How often do you floss? ______________

Do you think you have any decay/cavities? Yes No Do you suffer from chronic bad breath or bad taste? Yes No

Do your gums bleed easily when brushing or flossing? Yes No Do you have any jaw joint cracking or pain? Yes No

Dental Treatment Consent:

- I authorize the Dentists(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentists. This Form also authorizes this Practice to submit insurance claim forms and received payment directly from the Insurance Carrier with the notation: "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1.5% per month.

Patient/Guardian Signature: ______________________________ Date: ______________