|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | Cell #: | | | Date of Birth: |
| Address: | | City: | | State/Zip: |
| Home Phone: ( ) | SSN: | | | Sex: M F |
| Employer: | Phone: | | | Occupation: |
| Emergency contact: | | | Phone: | |
| When/where are the best times to reach you? : | | | | |
| Can we TEXT you to confirm appointments & send billing statements?  YES NO (circle one) | | | | |

By submitting this form & signing up for texts, you consent to receive appointment messages from Family & Cosmetic Dentistry at the number provider, including messages sent by autodialer. Consent is not a condition of purchase, message & data rates may apply. Message frequency varies. Unsubscribe at any time by replying, "STOP". Reply "Help" for assistance. For more information, visit our privacy policy attached here or found at www.alleghenysmiles.com

**WELCOME!**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental History

Date of Last Dental Visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last X-Rays\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently in pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you require premedication?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious trouble associated with any previous dental treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy with the way your smile looks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, what would change?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can we thank for referring you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

Bad breath\_\_\_ Loose teeth or broken fillings\_\_ Sensitivity while biting\_\_

Bleeding gums \_\_\_ Orthodontic treatment \_\_\_ Jaw, head or neck injuries\_\_

Blisters on lips or mouth\_\_\_ periodontal treatment \_\_\_ Jaw difficulty: clicking or pain\_\_

Grinding teeth\_\_\_ Lip or cheek biting\_\_\_ Sensitivity to cold/heat/sweets\_\_

Secondary Insurance

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber I.D.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance

Name of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber I.D.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_