

Paradise Family Dentistry

PATIENT INFORMATION

Welcome and thank you for choosing Paradise Family Dentistry! If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name (Last, First Middle) _____ Date _____

Male Female SSN _____ - _____ - _____ DOB ____/____/____

Address _____ Home Phone (_____) _____ - _____

City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Address _____ Work Phone (_____) _____ - _____

City _____ State _____ Zip Code _____

Person to contact in case of emergency: Name (Last, First) _____

Relationship to Patient _____ Phone (_____) _____ - _____

Whom may we thank for referring you ? _____

INSURANCE INFORMATION

Subscriber (Last, First) _____ Relationship to Patient _____

Employer _____ DOB ____/____/____ SSN _____ - _____ - _____

Insurance Co. _____

Group # _____ Policy # _____

I authorize the release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I also hereby assign payment of insurance benefits to Paradise Family Dentistry, otherwise payable to me, for services rendered.

_____/____/____

Signature of patient (or parent/guardian if patient is a minor)

Date

DENTAL HISTORY

Reason for today's visit _____

Former dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

Please mark "Yes" or "No" to indicate if you have had any of the following.

Y N

Y N

Y N

Bad breath

Foreign objects

Periodontal treatment

Bleeding gums

Grinding teeth

Sensitivity to cold

Blisters on lips/mouth

Gums swollen/tender

Sensitivity to heat

Burning sensation on tongue

Jaw pain/tiredness

Sensitivity to sweet

Chew on one side of mouth

Lip/cheek biting

Sensitivity when biting

Cigarette/pipe/cigar smoking

Loose teeth/broken fillings

Sores/growths in mouth

Clicking/popping jaw

Mouth breathing

Dry mouth

Mouth pain when brushing

How often do you floss? _____

Fingernail biting

Orthodontic treatment

Food collection between teeth

Pain around ear

How often do you brush? _____

