Dental Insurance Information:

Primary Insurance:_____ Employer:_____

Claim's Address: _____ City:_____ State:_____ Zip:_____

Employee:_____ ID/SS#:_____ Group#:_____ DOB:_____

Secondary Insurance:_____ Employer:_____

Claim's Address: _____ City:_____ State:_____ Zip:_____

Employee:_____ ID/SS#:_____ Group#:_____ DOB:_____

Dental History:

Previous Dentist:_____ Date of most recent dental exam x-rays:_____

What is your immediate dental concern?_____

Please answer yes or no to the following:

	Y	N
1. Are you having any dental problems or discomfort?	☐	☐
2. Do you / would you have any problems chewing bagels or other hard foods?	☐	☐
3. Have your teeth changed in the last 5 years, become shorter, thinner, or worn?	☐	☐
4. Are your teeth crowding or developing spaces?	☐	☐
5. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking popping)	☐	☐
6. Do you have tension headaches or sore teeth?	☐	☐
7. Do you wear or have you ever worn a bite appliance?	☐	☐
8. Have you had any cavities within the past 3 years?	☐	☐
9. Do you have a dry mouth?	☐	☐
10. Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
11. Do you avoid brushing any part of your mouth?	☐	☐
12. Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
13. Have you ever experienced gum recession?	☐	☐
14. Is there anyone with a history of periodontal disease in your family?	☐	☐
15. Do your gums bleed when brushing, flossing, or eating?	☐	☐
16. Have you ever whitened (bleached) your teeth?	☐	☐
17. Is there anything you would change about your smile?	☐	☐

I understand that the information that I have given is correct to the best of my knowledge, that it 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 the necessary dental services that I may need, and authorize the dentists to release any information about diagnosis or records to other health care practitioners or third party payers. I hereby authorize benefits to be paid directly to Dr. Southwood/ Dr. Paul/ Dr. Pope. I agree that I am responsible for any unpaid balance within 90 days for all services rendered on my behalf or my dependents, unless other financial arrangements have been made.

Parent/Patient Signature:_____ Date:_____