Patient Information

Name: _____ Preferred Name: _____
Today's Date: _____ Email _____
Birth Date: _____ Age: _____ SS#: _____
Home Address: _____ City, State, Zip: _____
Home Phone: _____ Employer: _____
Work Phone: _____ Occupation: _____
Cell Phone: _____ Driver's License #: _____
Spouse's Name: _____ Dependents' Names: _____
Spouse's Employer: _____ Spouse's Work Number: _____
Whom to notify in case of emergency: _____ Phone: _____
Who referred you to our office: _____ School/college: _____

Account Information

Person ultimately responsible for account: _____ Relation: _____
Billing Address: _____ Home Phone: _____ Work Phone: _____

Insurance Information

Primary Dental Insurance
Insurance Company: _____ Phone: _____
Insured's Name: _____ Birth Date: _____ SS# _____
Employer: _____ Group Plan Policy #: _____
Insurance Company Address: _____

Secondary Dental Insurance
Insurance Company: _____ Phone: _____
Insured's Name: _____ Birth Date: _____ SS#: _____
Employer: _____ Group Plan Policy #: _____
Insurance Company Address: _____

Financial Responsibility, Assignment of Insurance and Release
I have insurance coverage as listed above and assign to Smiles on Sandy any insurance benefits for services rendered. I am financially responsible for all charges whether paid by insurance or not. If I do not have insurance, I agree that I am responsible for charges incurred during my treatment. I authorize Smiles on Sandy to release all information necessary to secure payment.

Signature/date _____

Dental History

What is the primary reason for your visit to our practice today?
Are you currently in pain?
Your current dental health is: Good Fair Poor
When was your last complete dental evaluation?
Do you floss regularly? Y/N Do you brush regularly? Y/N
Have you ever been diagnosed or treated for the following dental conditions?

Y/N Bleeding Gums	Y/N Mobility of Teeth	Y/N Cold Sores	Y/N Oral Cancer
Y/N Deep Cleaning/Scaling	Y/N Osseous Surgery	Y/N Periodontal Disease	Y/N TMJ/TMD Y/N
Joint Pain	Y/N Hot/Cold Sensitivity	Y/N Toothbrush Abrasion	

Are you happy with the way your teeth look or function? Y/N If not, what would you change? _____

Do you have any special concerns regarding your visit: Fear, Time, Money, Tension, Other: _____

Describe any previous problems you may have had with past dental treatment or special areas of concern you would like to have addressed by Dr. Daby and his staff: _____