PATIENT INFORMATION

Date _____ SS# _____

Patient Name _____

Address_____

City_____ State_____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____

E-Mail _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced

Patient Employer/ School_____

Occupation_____

Employer/ School Phone _____

Spouse's Name_____

Birth date _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Group # _____

Is patient covered by additional Insurance?

☐ Yes ☐ No

Subscribers Name _____

Birth date _____ SS# _____

Relationship to Patient _____

Insurance Company _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Marc L. Marlette, DMD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This content will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Representative

_____

Please print name

_____ _____

Date Relationship to Patient

PHONE NUMBERS

Home _____ Work_____ Ext _____ Cell Phone_____

Spouse's Work _____Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT:

Name_____ Relationship_____

Home_____ Work Phone _____

DENTAL HISTORY

Reason for Today's Visit _____

_____

Former Dentist _____

_____

City/State_____

Date of Last Dental Visit _____

_____

Date of Last Dental X-Rays _____

_____

Place a mark "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐Y ☐ N	Burning sensation on tongue	☐Y ☐ N
Bleeding gums	☐Y ☐ N	Chew on one side of mouth	☐Y ☐ N
Blisters on lips or mouth	☐Y ☐ N	Cigarette, Pipe, or Cigar Smoking	☐Y ☐ N
		Clicking or popping jaw	☐Y ☐ N
		Dry mouth	☐Y ☐ N
		Fingernail Biting	☐Y ☐ N
		Food collection between teeth	☐Y ☐ N
		Foreign objects	☐Y ☐ N
		Grinding teeth	☐Y ☐ N
		Gums swollen or tender	☐Y ☐ N
		Jaw pain or fatigue	☐Y ☐ N
		Lip or cheek biting	☐Y ☐ N
		Loose teeth or broken fillings	☐Y ☐ N
		Mouth breathing	☐Y ☐ N
		Mouth pain, brushing	☐Y ☐ N
		Orthodontic treatment	☐Y ☐ N
		Pain around ear	☐Y ☐ N
		Periodontal treatment	☐Y ☐ N
		Sensitivity to cold	☐Y ☐ N
		Sensitivity to hot	☐Y ☐ N
		Sensitivity to sweets	☐Y ☐ N
		Sensitivity when biting	☐Y ☐ N
		Sores or growths in your mouth	☐Y ☐ N

How often do you floss? _____

How often do you brush? _____

Do you use a rinse? _____