



### Patient Information

Patients Name \_\_\_\_\_  
Last First Initial

Birthdate \_\_\_\_\_

If Child  
 Parents Name \_\_\_\_\_  
Last First Initial

How do you wish to be Addressed \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor   
 Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_ How Long \_\_\_\_\_

Spouse \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_ How Long \_\_\_\_\_

Who is Responsible for this Account \_\_\_\_\_

Method of Payment Check  Credit Card  Cash

Purpose of Visit \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

How did you hear about our office \_\_\_\_\_

Preferred doctor: \_\_\_\_\_

Patients Social Security # \_\_\_\_\_

Spouse/Parent Social Security # \_\_\_\_\_

DL # \_\_\_\_\_



### Dental Insurance

Who carries this plan \_\_\_\_\_

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

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

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

Cardholder BD \_\_\_\_\_

Cardholder SSN \_\_\_\_\_

Is this patient covered by another plan also?  Yes  No

Name of Carrier \_\_\_\_\_

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

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

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

Cardholder BD \_\_\_\_\_

Cardholder SSN \_\_\_\_\_

#### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

\_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Valley Dental Spa 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 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 or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Gaurdian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Gaurdian or Personal Representative

\_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_



### Phone Numbers

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_ E-mail \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ 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 on "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
		Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	
		Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No		