ALL SMILES DENTAL CARE

Patient Information

Date: Jan 21 2022

Gender: Male | Female

Title: None | Mr. | Mrs. | Miss | Ms. | Dr.

First Name: First

MI: Middle Initial

Last Name: Last

Preferred Name: Common

Birthdate

Social Security #: SSN

Cell: Phone

Home: Phone

Work: Phone

EXT: Text

Address: Address

City: City

State: State

Zip Code: 12144 or 12144-7050

Email: Email

How did you learn of our office? Please Select

Marital Status: Single | Married | Divorced | Widowed | Significant Other

Appointment Preference: None | AM | PM

On Short Notice? Yes | No

For your convenience our office can communicate with you by text or email. It's okay for the office to

Text me | Email me | Send me appointment reminders

Patient Is (Select All That Apply): Patient | Policy Holder | Responsible Party

Employed: Full-Time | Part-Time | N/A

Student: Full-Time | Part-Time | N/A

In case of emergency, please contact: Text

Phone: Phone

Relation: Text

Who is responsible for your account?

Self | Spouse | Father | Mother | Other

Insurance Information

Do you have Insurance? Yes | No

Dental Information

Reason for today's visit: Text

Are you in pain? Yes | No

Please indicate any of the following problems by selecting the corresponding box:

Discomfort, clicking, or popping in jaw | Lost / broken filling(s) | Stained teeth | Difficulty closing jaw

Red, swollen, or bleeding gums | Teeth grinding / clenching | Locking jaw | Difficulty opening jaw

A removable dental appliance | Ringing in ears | Bad breath | Loose / shifting teeth

Blisters / sores in or around the mouth | Broken / chipped tooth | Burning tongue / lips | Gum Disease

Prolonged bleeding from an injury / extraction | Toothache | Swelling / lumps in mouth

Recent infections or sore throat | Food caught between teeth | Other

If other, please explain

Text

My teeth are sensitive to:

Hot | Cold | Sweets | Biting

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this dental office 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature

Sign Here

Date

Jan 21 2022

I hereby acknowledge that I have received a copy of this offices Notice of Privacy Practices. I may refuse to sign this acknowledgement. To obtain a paper copy I may request it from the office or the website.

Signature

Sign Here

Date

Jan 21 2022

Submit