PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate (mm/dd/yy)_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____

ADDRESS AND HOME PHONE

Address_____

Address 2_____

City_____ Postal Code_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] CellPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber ID # _____

Insurance Company _____

Employer_____ Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____ Subscriber ID # _____

Insurance Company _____

Employer_____ Group #_____

Date of Birth of Subscriber:_____

FINANCIAL AGREEMENT

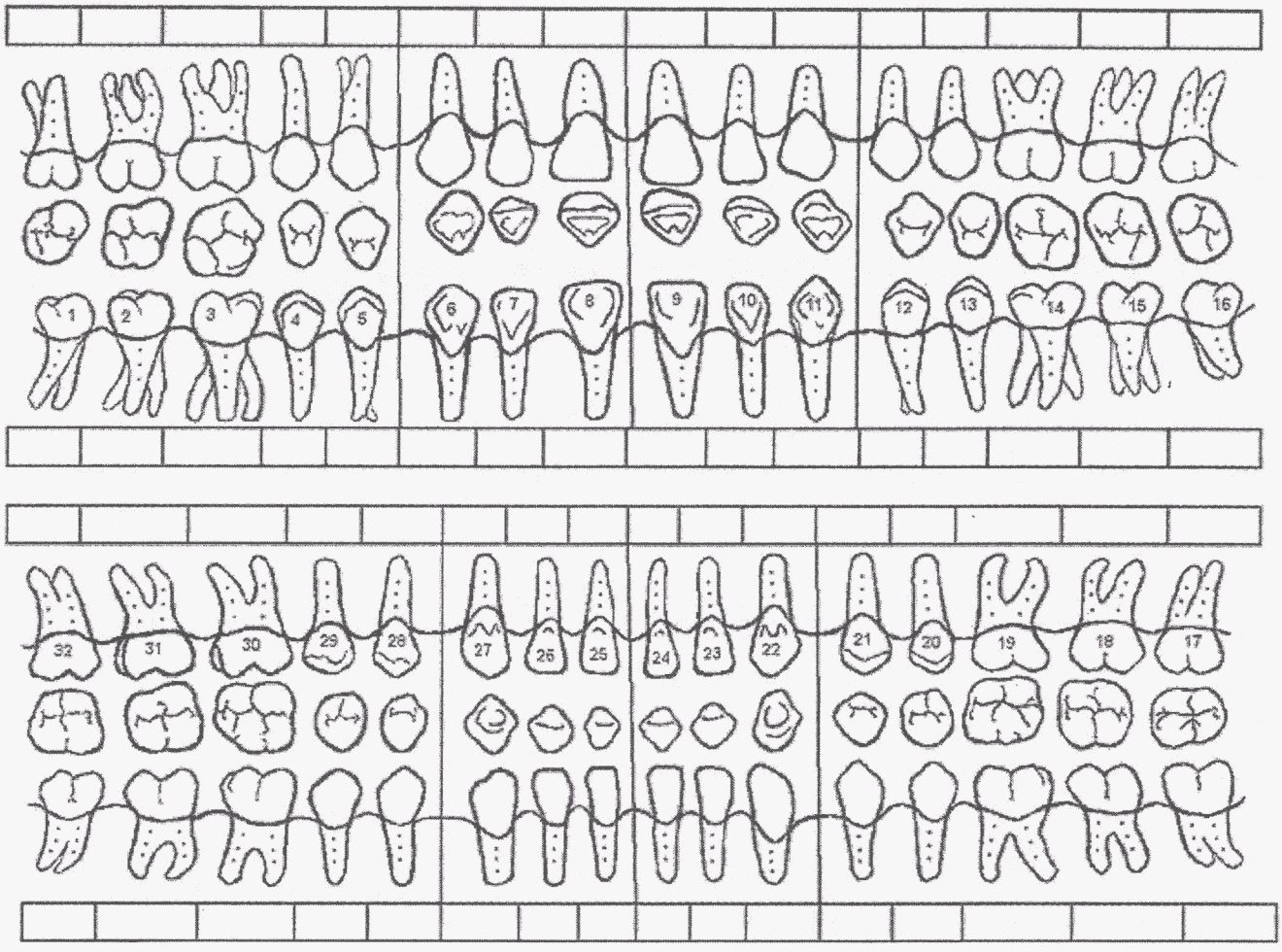
* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I will pay a fee for appointments broken without 48 hours notice. Missed appointment fees are $50.00/30min.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature_____ Date_____



EXTRAORAL: General Facial Form_____ Lymph Nodes_____

TMJ: Joint Sounds: None Clicking_____ Crepitus_____

INTRAORAL: Lips_____ Cheeks_____ Tongue_____ Floor of mouth_____
Salivary Glands_____ Hard Palate_____ Soft Palate_____
Oral Pharnyx_____ Frenum_____ Tori_____

OCCLUSION: Angle Classification: Class I II III Div. 0 1 2
Midline_____ Crossbite_____
Overjet_____mm Overbite_____%

PERIODONTAL:

Homecare:	Good	Fair	Poor
Colour:	Normal	Marginal	Chronic
Contour:	Normal	Marginal	Chronic
Consistency:	Normal	Edematous	Exudate
Recession:	Normal	Early	Moderate

PSR

Plaque:	Generalized	Localized	Light	Moderate	Abundant
Calculus: Sub	Generalized	Localized	Light	Moderate	Abundant
Supra.	Generalized	Localized	Light	Moderate	Abundant
Stain:	Generalized	Localized	Light	Moderate	Abundant
Attached Gingiva:	Normal	MAG			