THANK YOU FOR CHOOSING GEORGETOWN DENTAL

PATIENT INFORMATION

Last Name: _____First Name: _____ Middle Initial: _____

Marital Status: _____ DOB: _____ Age: _____ Sex: _____M _____F

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____Patient's Social Security Number: _____

If patient is a minor, provide parent or guardian's name: _____

Reason for this visit: _____ Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION/GUARANTOR

Last Name: _____ First Name: _____ Middle Initial: _____ DOB:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____Social Security Number: _____

Driver's License #_____ State: _____ Relationship to Patient: _____

Employer: _____Occupation: _____

Spouse Information

Name: Last: _____ First: _____ DOB:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Dental Insurance

Subscriber's Name _____DOB: _____ Subscriber's Employer _____

Insurance Company _____Insurance Company Phone #_____

Insurance Company Address_____ City_____ State_____ Zip_____

Subscriber's Member ID#_____ Group #_____ **Subscriber's SSN** _____

Secondary Dental Insurance

Subscriber's Name _____ DOB:_____ Subscriber's Employer_____

Insurance Company _____Insurance Company Phone #_____

Insurance Company Address_____ City_____ State_____ Zip_____

Subscriber's Member ID#_____ Group #_____ **Subscriber's SSN** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Bruce E. Steele or Dr. Sinclair R. Davis 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 agent for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____ _____
Signature of Patient, Parent or Guardian Date Please print name of Patient, Parent or Guardian

_____ _____ _____ _____
Signature Date Signature Date

_____ _____ _____ _____
Signature Date Signature Date

_____ _____ _____ _____
Signature Date Signature Date

DENTAL AND MEDICAL HISTORY

It is important that we know your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to fill out this questionnaire.

Dental History

How long since you have seen a dentist? _____ Last COMPLETE Dental Exam Date? _____

Name of Previous Dentist? _____Last FULL MOUTH X-RAYS Date? _____

Any CURRENT dental problems? _____

Are you apprehensive about dental treatment?	Y	N	Have you had any periodontal (gum) treatment?	Y	N
Do your gums bleed, feel tender or irritated?	Y	N	Are your teeth sensitive to hot, cold, sweets, pressure?	Y	N
Are you unhappy with the appearance of your teeth?	Y	N	Are you aware of grinding or clenching your teeth?	Y	N
Do you have Headaches, earaches or neck pain?	Y	N	Have you worn braces on your teeth? (orthodontics)	Y	N
Do you have discolored teeth that bother you?	Y	N	Would you like your smile to look better or different?	Y	N
Do you regularly floss your teeth?	Y	N	**Are you interested in teeth whitening**	**Y**	**N**

Medical History

Do you have any current health problems? _____ Are you under Physician's care now? _____

For what? _____

What Medications are you currently taking? _____

Are you pregnant? _____ Do you smoke? _____

Circle any of the following which you have presently or have had in the past

Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma
Heart Murmur	Heart Problems	Hepatitis	High Blood Pressure	HIV Positive	Jaundice
Kidney Problems	Low Blood Pressure	Rheumatic Fever	Stroke	Tuberculosis	
Sexually Transmitted Diseases		Other _____			

Are you allergic to or have you have you reacted adversely to any of the following medications?

Aspirin	**Local Anesthetic**	**Erythromycin**	**Barbituates**	**Codeine**
Penicillin	**Latex**	**Sulfa**	**Iodine**	**Other _____**

CONSENT AND RESPONSIBILITY STATEMENT

I, _____ hereby authorize and request the performance of dental services for myself or for

_____, Age _____ for the services provided for myself or the above named.

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or the supervised staff for diagnostic purposes or dental treatment.

_____	_____	_____	
Signature of Responsible Party	Date	Please Print Name of Patient, Parent, or Guardian	
_____	_____	_____	_____
Signature	Date	Signature	Date
_____	_____	_____	_____
Signature	Date	Signature	Date
_____	_____	_____	_____
Signature	Date	Signature	Date
_____	_____	_____	_____
Signature	Date	Signature	Date