Patient Information

Name:_____ Preferred Name:_____
Today's date:_____ Email:_____
Birth Date:_____ Age:_____ SS#:_____
Home Address:_____ City, State, Zip:_____
Home Phone:_____ Employer/School:_____
Work Phone:_____ Occupation:_____
Cell Phone:_____ Driver's License #_____
Spouse's Name:_____ Dependent's Names:_____
Spouse's Employer:_____ Spouse's Work Phone:_____
Whom to notify in case of emergency:_____ Phone:_____
Whom may we thank for referring you?_____

Dental History

What is the primary reason for your visit to our practice today?_____
Are you currently in pain?_____
How would you describe your current dental health? Good Fair Poor
When was your last complete dental evaluation?_____
Do you floss regularly? Y/N Do you brush regularly? Y/N
Have you ever had or been treated for the following?
Y/N Bleeding Gums **Y/N** Cold Sores **Y/N** Oral Cancer
Y/N Mobility of Teeth **Y/N** Periodontal Disease **Y/N** Joint Pain/TMJ/TMD
Y/N Hot/Cold Sensitivity **Y/N** Toothbrush Abrasion
Are you happy your teeth **Y/N** If not, what would you change? _____
Do you have any special concerns regarding your visit? Fear/Anxiety/Time/Finances/Other_____
Please describe any previous problems you may have had with past dental treatment or special areas of concern you would like to have addressed by Dr. Daby and his staff: _____

Account / Insurance Information

Person ultimately responsible for account:_____ Relation:_____
Billing Address:_____ Home Phone:_____ Work Phone:_____

Primary Dental Insurance
Insurance Company:_____ Phone:_____
Insured's Name:_____ Birth Date:_____ SS#:_____
Employer:_____ Group Plan Policy :_____
Insurance Company Address:_____

Secondary Dental Insurance
Insurance Company:_____ Phone:_____
Insured's Name:_____ Birth Date:_____ SS#:_____
Employer:_____ Group Plan Policy:_____
Insurance Company Address:_____

Financial Responsibility, Assignment of Insurance and Release
I have insurance coverage as listed above and assign to Blue Sky Dental any insurance benefits for services rendered. I am financially responsible for all charges whether paid by insurance or not. If I do not have insurance, I agree that I am responsible for charges incurred during my treatment. I authorize Blue Sky dental to release all information necessary to secure payment.

Signature:_____ **Date**:_____