# WELCOME

## PATIENT INFORMATION

Date: June 25, 2009

Patient:

First Middle Initial Last

Preferred Name:

Address:

City, State Zip

Email:

Phone Number:

Work Number:

Mobile Number:

Emergency Contact:

Emergency Contact Phone Number:

Sex: ☐ Male or ☐ Female Birthdate:

Social Security Number:

Patient's Employer:

Employer's Address:

City, State Zip

Marital Status: ☐ Married ☐ Single ☐ Divorced

Spouse's Name:

If Patient is a child, Parent's name(s):

**Whom may we thank for referring you?**

(i.e.: phonebook, insurance, name of person, etc.)

## DENTAL INSURANCE

Person Providing Insurance:

Social Security Number:

Date of Birth: Employer:

Relationship to Patient: Self

Insurance Company:

Group #:

Is Patient covered by additional insurance? ☐ Yes ☐ No

Person Providing Secondary:

Social Security Number:

Relationship to Patient:

Date of Birth: Employer:

Insurance Company:

Group #:

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Marengo 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Self

Relationship

## DENTAL HISTORY

Your current dental health is: Good Do your gums ever bleed? Yes

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No - Comments:

Do you like the color of your teeth? ☐ Yes ☐ No - Comments:

Do you like the size and shape of your teeth? ☐ Yes ☐ No - Comments:

What would you change about your smile if you could?

Approximate date of your last dental visit:

Why did you leave your last dentist?

Why have you come to the dentist today?