PATIENT INFORMATION

Date_____ SSN_____

Patient Name_____

Preferred Name_____

Birthdate_____ Age_____

Address_____

City_____ State_____

Zip_____ Sex: Male / Female

Home Phone_____

Work Phone_____

Cell Phone_____

Email_____

Emergency Contact: Name / Phone / Relationship

_____

Patient Employer_____

Occupation_____

Marital Status: _____

Whom may we thank for referring you?

_____

Dental Insurance

Who is responsible for this account?

_____

Relationship to patient?_____

Insurance Company_____

Group #_____

Subscriber's Name_____

Birthdate_____ SSN_____

Relationship to patient?_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with above named insurance company and assign directly to Dr. Raymond Gyselinck, JR, DDS, PC, 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 and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____

Signature of Policy Holder

DENTAL HISTORY

Reason for today's visit? _____

_____

Former dentist_____

Date of last dental visit?_____

_____

Last dental x-rays?_____

_____

Please circle "yes" or "no" to indicate if you have ever had any of the following:

Bad breath	Yes / No
Bleeding gums	Yes / No
Clicking or popping jaw	Yes / No
Dry mouth	Yes / No
Food collection	Yes / No
Grinding teeth	Yes / No
Jaw pain	Yes / No
Mouth breathing	Yes / No

Mouth pain	Yes / No
Orthodontic treatment	Yes / No
Periodontal treatment	Yes / No
Sensitivity to cold	Yes / No
Sensitivity to heat	Yes / No
Sensitivity to sweets	Yes / No
Are you nervous during dental procedures?	Yes / No

How often do you brush?_____

How often do you floss?_____