WELCOME

PATIENT INFORMATION

Name (First, Last)_____

Address _____

City_____ State_____Zip_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-Mail: _____

Date of Birth: _____

SS# _____

☐Married ☐Single

☐Minor ☐Divorced

Employer/School_____

Employer/School Address_____

_____

Employer/School Phone _____

Spouse's Name _____

Spouse's Date of Birth _____

SS#_____

How did you hear about us?

_____

Incase of Emergency Contact:_____

Cell Phone_____

DENTAL INSURANCE

Subscriber's Name _____

Date of Birth_____ SS# _____

Relationship to patient _____

Insurance Co _____

Group # _____

Secondary Insurance? _____

Subscribers Name _____

Date of Birth_____ SS# _____

Insurance Co _____

Group # _____

Assignment and Release

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Dr. Minal Patel DDS Inc 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.

Dr. Minal Patel DDS may use my healthcare information and may disclose such information to the above named company and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

DENTAL HISTORY

Please mark "X" for the following questions

Do your gums bleed when you brush or floss?	☐Yes ☐No	Do you grind your teeth?	☐Yes ☐No
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐Yes ☐No	Do you have sores or ulcers in your mouth?	☐Yes ☐No
Is your mouth dry?	☐Yes ☐No	Do you wear dentures ot partials?	☐Yes ☐No
Have you had any periodontal (gum) treatment?	☐Yes ☐No	Do you participate in any extreme or team sports?	☐Yes ☐No
Have you ever had orthodontic (braces) treatment?	☐Yes ☐No	Have you had any injury in your head or mouth?	☐Yes ☐No
Have you had any problems with previous dental work?	☐Yes ☐No	Date of last dental exam?_____	
Do you drink bottled or filtered water?	☐Yes ☐No	Treatment?_____	
Are you in any dental pain or discomfort?	☐Yes ☐No	X-rays?_____	
Do you have earaches or neck pains?	☐Yes ☐No	What brings you in today?_____	
Do you have any clicking, popping, or discomfort in the jaw?	☐Yes ☐No	How do you feel about your smile?_____	