Weston Dental Design
GROUP

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Phone _____ Alt. Phone _____
Name _____ SS/HIC/Patient ID# _____
Address _____ Email _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐Married ☐Widowed ☐Separated ☐Divorced
☐ Minor ☐ Single ☐ Partnered for _____years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Relation to Patient _____ Birthdate _____ Soc. Sect. # _____
Address (If different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____
Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ 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 agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or the one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient