WELCOME!

Name:	Cell #:	Date of Birth:
Address:	City:	State/Zip:
Home Phone: ( )	SSN:	Sex: M F
Employer:	Phone:	Occupation:
Emergency contact:	Phone:	
When/where are the best times to reach you? :		
Can we TEXT you to confirm appointments & send billing statements? YES NO (circle one)		

By submitting this form & signing up for texts, you consent to receive appointment messages from Family & Cosmetic Dentistry at the number provider, including messages sent by autodialer. Consent is not a condition of purchase, message & data rates may apply. Message frequency varies. Unsubscribe at any time by replying, "STOP". Reply "Help" for assistance. For more information, visit our privacy policy attached here or found at www.alleghenysmiles.com

Primary Insurance

Name of Policy Holder__________________
Relationship to the Patient_______________
Birthdate___________ SSN______________
Address____________________________
Home Phone_________________________
Policy Holder Employer________________
Employer Phone number________________
Insurance Company______________________
Address__________________________________
Subscriber I.D.#___________________________
Group #__________________________________

Secondary Insurance

Insured Name _______________________
Relationship to the Patient_______________
Birthdate____________ SSN_______________
Address_____________________________
Home Phone__________________________
Policy Holder Employer_________________
Employer Phone number_________________
Insurance Company______________________
Address__________________________________
Subscriber I.D.#___________________________
Group #_________________________________

Dental History

Date of Last Dental Visit_________________________ Date of Last X-Rays______________________
How often do you brush?______________________ Are you currently in pain?____________________
How often do you floss?________________________ Do you require premedication?_________________
Have you had any serious trouble associated with any previous dental treatment?____________________
Are you happy with the way your smile looks?____
If not, what would change?____
Who can we thank for referring you to us?____
Please check all that apply:

Bad breath___	Loose teeth or broken fillings__	Sensitivity while biting__
Bleeding gums ___	Orthodontic treatment ___	Jaw, head or neck injuries__
Blisters on lips or mouth___	periodontal treatment ___	Jaw difficulty: clicking or pain__
Grinding teeth___	Lip or cheek biting___	Sensitivity to cold/heat/sweets__

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.
Signature____Date_________________________