Welcome to Graber Dental

About You

Name: ___________________________________ Preferred Name: _________________________________

□ Male □ Female Birthdate: ____________ Age:_______ SSN: __________________________________

Email Address: ____________________________________

Home Address: ____

□ Single □ Married □ Divorced □ Separated □ Widowed

Hm # _____________________ WK # ______________________ Cell# _______________________________

Employer: ______________ Occupation:______________ Employer address: _____________________________

Where & When is the best time to reach you? ____

Whom may we thank for referring you?_________________ Other family members seen by us: ______________

Emergency contact Name:___________________________ phone #: ____________________ Relation:_________

Spouse Information

Name: _____________________________ Birthdate: ___________________ SSN: _______________________

Wk # ______________________ Cell # : ______________________ Email Address: _______________________

Employer: _____________________________________

Primary Insurance Information

Ins. Co. Name: _________________________________ Phone Number: _______________________

Ins. Co. Address: _____________________________________ Insured's Employer: ________________________

Insured's ID #: ___________________________ Group #: _______________

Insured's Name: _______________________ Insured's birthdate: ___________ Relation to patient: ____________

Secondary Insurance Information

Ins. Co. Name: _________________________________ Phone Number: _______________________

Ins. Co. Address: _____________________________________ Insured's Employer: ________________________

Insured's ID #: ___________________________ Group #: _______________

Insured's Name: _______________________ Insured's birthdate: ___________ Relation to patient: ____________

Reason for seeking dental care at this time? ____

Date of last dental visit Reason? ____________________ Date of last X-rays? ________________________

Former dentist ______________________________ City/state ___________________________________

How often do you: **Brush** ________ times per_______ **Floss** _________ times per __________

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Do you have or have you ever had any of the following? Please check all that apply and comment.

_ Aching or sensitive teeth _ Broken filling _ Areas of food traps _ Unfavorable dental experience
_ Sensitive or bleeding gums _ Loose teeth _ Dry mouth _ Growths/lesions in your mouth
_ Broken or missing teeth _ Bad breath _ Cold sores _ Clicking or popping in jaw
_Grinding or clenching _ Swollen glands _ Jaw pain or tiredness _ Difficulty opening wide
_Swelling or lumps in mouth _ Gum infection _ Orthodontic treatment _ Other ___________________
____

If you could change your smile, what would you change?

_ Remove unsightly fillings _ Straighten teeth _ Change shape of teeth _ Close gaps between teeth
_ Replace missing teeth _ Whitening _ Make teeth same color _ Other

Insurance agreement

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions.
I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that maybe indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.
I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____________________________________ ________________________ ____________________

Signature of patient or Authorized responsible party Relationship Date