Welcome to Graber Dental

Name: _________________________________Preferred Name: __________________________________

Male ☐ Female ☐ Unspecified ☐ Birthdate: ___________ SSN:___________________________

Preferred Pronoun/s: They/Them ☐ She/Her ☐ He/Him ☐ Other: _________________________

Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Domestic Partnership ☐ Other ☐

Home Address: _____________________________________ City: ___________________ Zip: ____________

Home #: ______________________ Cell #: ___________________________Work #: _________________________

Employer: _______________ Occupation: _______________ Employer address: ______________________________

Where and when is the best time to reach you? ____

Whom may we thank for referring you? ___________________Other Family members by us: __________________

Emergency Contact Name: ____________________ Phone #: ____________________ Relationship: _______________

Spouse Information

Name: ________________________ Birthdate: __________ SSN: _______________ Employer: ___________

Cell #: _______________________ Work #: ___________________ Email: ______________________________

Primary Insurance Information

Insurance co. Name: _______________________________________ Phone #: ______________________

Ins. Address: _______________________________________ Insured's Employer: ___________________

Insured's ID #: ______________________________________ Group #: _____________________________

Name of Policy Holder: ________________________ Birthdate: ______ Relationship to patient: __________

Secondary Insurance Information

Insurance co. Name: _______________________________________ Phone #: ______________________

Ins. Address: _______________________________________ Insured's Employer: ___________________

Insured's ID #: ______________________________________ Group #: _____________________________

Name of Policy Holder: ________________________ Birthdate: ______ Relationship to patient: __________

Reason for seeking dental care: ____

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

Please check all that apply

- □ Had complications from past dental treatment
- □ Have you had a reaction to local anesthetic
- □ Had any teeth become loose on their own
- □ Experience dry mouth
- □ Difficulty chewing
- □ Snore or wake up frequently during the night
- □ Notice an unpleasant odor or taste in your mouth
- □ Had trouble getting numb
- □ Had braces or orthodontic treatment
- □ Food gets trapped between any teeth
- □ Clench or grind your teeth
- □ Gums bleed when brushing or flossing
- □ Wear or have worn a dental appliance
- □ Experience a burning sensation in your mouth
- □ Experience a popping and/or clicking in you jaw joing
- □ Treated for gum disease or were told you have lost bone around your teeth
- □ Are there any teeth sensitive to hot, cold, biting, sweets, or brushing

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 insurance information I provided 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 the 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 she 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 may be indicated. I authorize and consent that the doctor employ any such assistance as 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 Parent/Guardian **Relationship** **Date**