Dental History

1 Are you having discomfort at this time? _____ Yes no

If yes please specify_____

2. Previous Dentist _____Last visit_____

3. Have you ever had a problem with local or general anesthetic? Yes no

4. Would you be interested in improving the appearance of your teeth? Yes no

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Do you currently experience?

___Loose teeth ___ Bleeding gums ___ sore gums

___Sensitive teeth ___ Bad breathe _____Popping or clicking in the jaw joints

___Missing teeth ___Headache ___ Spaced/or crooked teeth

___Unsatisfactory dentures

Insurance Information

Policy holder Insurance Information:

Name of policy holder_____

Date of birth_____

Name, Insurance Co_____Policy#_____

Certificate/ ID Number_____

Place of Employment_____

Are you claiming from more than one insurance company?

Yes No

If yes, complete the following

Name of policy holder_____

Date of birth_____

Name, Insurance Co _____Policy#_____

Certificate /ID Number_____

Place of Employment_____

Other than the policy holder(s) above, Indicate patient's name and relationship to insurance policy Holder by encircling the following ....

Patient's name_____ Spouse or Dependent

Patient's name_____ Spouse or Dependant

Patient's name _____Spouse or Dependant

CONSENT

To the best of my knowledge, the above information is correct.

I, _____,Consent TO THE PERFORMING OF THE DENTAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE FOR MYSELF & FAMILY MEMBERS.

I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THESE PROCEDURES. I AUTHORIZE RELEASE, TO MY INSURER / PLAN ADMINISTRATOR, THE INFORMATION CONTAINED IN CLAIMS AND ESTIMATES MAILED OR SUBMITTED ELECTRONICALLY BY ROCKCLIFFE DENTAL & DENTURE CENTRE.

Patient/parent/guardian signature_____Date:_____

Dentist Signature_____Date_____