Reynolds
FAMILY DENTISTRY, PA

Patient Information

Date________________

Patient Full Name ________________________________

Physical Address ________________________________

Mailing Address ________________________________

City/State/Zip ________________________________

Telephone #'s: Home:__________ Work: ______________

Best time and place to reach you: ________________

Cell Phone # ______________________ Sex: ☐M ☐F

Age:__________ Birthdate: ______________________

Email:____

Whom may we thank for referring you to our practice?

____

Patient Social Security # ________________________

Occupation_____________________________________

Employer ______________________________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Information (if applicable)

Name____

Age:________ Birthdate: _________________________

In the event of an emergency, please contact:

Name__________________________________

Home Phone # ___________________________

Relationship ___________________________

Work Phone # ___________________________

Dental Insurance Information

Do you currently have dental insurance coverage? ☐ Yes ☐ No

If so, please complete the following information to help us in filing your insurance claims:

Primary Insurance Information:

Subscriber's Name ______________________________________

Age________________ Birthdate ___________________________

Social Security # _______________________________________

Employer ____

Insurance Company ______________________________________

Group # ____

Relationship to Patient ___________________________________

The undersigned hereby authorizes Reynolds Family Dentistry, PA to file insurance claims on behalf of the patient. Futhermore, it is understood that the filing of claims is done as a service to the patient and that any portion of the treatment not covered and/or paid for by the insurance company for any reason is the understood responsibility of the patient/responsible party. The estimated co-pay is due at the time services are rendered. Any difference in the estimated amount and the actual amount paid by the insurance company will be billed to the patient/credited to the patient's account, whichever applies.

Patient Signature ______________________________________ Date ______________

Responsible Party (if minor)_____________________________ Date ______________

Relationship to Patient_________________________________

Dental History

Former Dentist:_______________________________ City/State: _______________________

Date of Last Dental Visit:___________________ How often do you brush?_______________

Date of Last Dental X-Rays:__________________ How often do you floss?________________

Please check **"Yes"** or **"No"** to indicate if you have or have had any of the following.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Sores/growths in mouth	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Sensitivity to biting	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No	Loose teeth	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No	Broken fillings	☐ Yes	☐ No
Cigarette/Pipe/Cigar smoking	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No
Smokeless Tobacco	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No	Bad Breath	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pyorrhea	☐ Yes	☐ No	Bleeding Gums	☐ Yes	☐ No
Jaw pain and/or tiredness	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No	Mouth Breathing	☐ Yes	☐ No