



WELCOME

PATIENT INFORMATION

Patient _____ Date _____
 Home Address _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Email Address _____
 Sex: M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
 Patient SS # _____
 Occupation _____
 Employer _____
 Employer's Address _____
 Employer's Phone _____
 Spouse's Name _____
 Birthdate _____
 Occupation _____
 Spouse's Employer _____
 Spouse's Employer Address _____
 Spouse's Employer Phone _____
 Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. _____
 Group# _____
 Is patient covered by additional insurance? Yes No
 If Yes, Insurance Co _____
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Breaux all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

 Responsible Party's Signature

 Relationship Date

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell _____ Spouse's cell _____
 Best time and place to reach you _____

EMERGENCY CONTACT: (Specify someone who does not live in your household)

Name _____ Relationship _____
 Home Phone _____ Work Phone _____ Cell Phone _____

DENTAL HISTORY

Please mark each box "Yes" or "No" to indicate if you have or had any of the following:

Reason for today's visit _____	Bad taste <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose tooth or broken filling <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental x-rays _____	Cigarette, pipe or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
What would you change about your teeth?	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Dark teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold/heat/sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Unightly teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

