THE SMILE LOUNGE
Aaron Breaux, D.D.S.

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 herby 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 _____
_____
Former Dentist _____
City/State _____
Date of last visit _____
Date of last dental x-rays _____
What would you change about your teeth?
_____

Bad taste	() Yes () No	Jaw pain or tiredness	() Yes () No
Bleeding gums	() Yes () No	Lip or cheek biting	() Yes () No
Blisters on lips or mouth	() Yes () No	Loose tooth or broken filling	() Yes () No
Burning sensation on tongue	() Yes () No	Mouth breathing	() Yes () No
Chew on one side of mouth	() Yes () No	Mouth pain, brushing	() Yes () No
Cigarette, pipe or cigar smoking	() Yes () No	Orthodontic treatment	() Yes () No
Clicking or popping jaw	() Yes () No	Periodontal treatment(	() Yes () No
Dark teeth	() Yes () No	Sensitivity to cold/heat/sweets	() Yes () No
Dry mouth	() Yes () No	Sensitivity when biting	() Yes () No
Fingernail biting	() Yes () No	Sores or growths in mouth	() Yes () No
Food collection between teeth	() Yes () No	Unsightly teeth	() Yes () No
Grinding teeth	() Yes () No	How often do you floss? _____	
Gums swollen or tender	() Yes () No	How often do you brush? _____	