

*Our patients are also our friends. We'd like to get some more information about you so that we can get to know you better.*

### Patient Information

A B C

Date \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Who is your general dentist? \_\_\_\_\_ E-Mail \_\_\_\_\_

### Responsible Party Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

<p>Insured's Name _____</p> <p>Birthdate _____ Social Security # _____</p> <p>Insurance Co. _____</p> <p>Group No. _____ Local No. _____</p> <p>Ins. Co. Address _____</p> <p>_____</p> <p>Ins. Phone No. _____</p>	<p>Do you have dual coverage? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>If Yes:</b> Insured's Name _____</p> <p>Birthdate _____ Social Security # _____</p> <p>Insurance Co. _____</p> <p>Group No. _____ Local No. _____</p> <p>Ins. Co. Address _____</p> <p>_____</p> <p>Ins. Phone No. _____</p>
<p>I HEREBY AUTHORIZE PAYMENT DIRECTLY TO GILBERT H. SNOW, D.D.S. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.</p> <p>_____ (SIGNED INSURED PERSON) (DATE)</p> <p>Coverage ____% Eff. Date ____ Eligibility ____</p> <p>REMARKS: _____</p> <p>_____</p>	<p>I HEREBY AUTHORIZE PAYMENT DIRECTLY TO GILBERT H. SNOW, D.D.S. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.</p> <p>_____ (SIGNED INSURED PERSON) (DATE)</p> <p>Coverage ____% Eff. Date ____ Eligibility ____</p> <p>REMARKS: _____</p> <p>_____</p>

### Emergency Information

Name of nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Complete Address \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

Is the patient in good health? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the patient under the care of a physician? \_\_\_\_\_

If so, explain \_\_\_\_\_

Presently taking any medication? \_\_\_\_\_

If so, explain \_\_\_\_\_

Does the patient have any history of: (please check yes or no)

Y N	Y N	Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Frequent Colds	<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Aids	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Heart trouble	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Kidney or liver disease	<input type="checkbox"/> <input type="checkbox"/> T.B.	<input type="checkbox"/> <input type="checkbox"/> Blood disorders	
<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Brain injury	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Hearing difficulties	

or any other disorder. If so, please outline: \_\_\_\_\_

Have tonsils and adenoids been removed? \_\_\_\_\_

Have you been on Phen-Fen or Redux?   <sup>Y N</sup> If yes, for how long? \_\_\_\_\_

Please check yes or no if you have ever had any of the following habits:

Y N	Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Thumb sucking	<input type="checkbox"/> <input type="checkbox"/> Mouth breathing	<input type="checkbox"/> <input type="checkbox"/> Grinding of teeth	<input type="checkbox"/> <input type="checkbox"/> Tongue biting	<input type="checkbox"/> <input type="checkbox"/> Smoking
<input type="checkbox"/> <input type="checkbox"/> Nail Biting	<input type="checkbox"/> <input type="checkbox"/> Tongue thrusting	<input type="checkbox"/> <input type="checkbox"/> Speech disorders	<input type="checkbox"/> <input type="checkbox"/> Abnormal breathing	
<input type="checkbox"/> <input type="checkbox"/> Tongue sucking	<input type="checkbox"/> <input type="checkbox"/> Lip biting			

Approximate age of first tooth: \_\_\_\_\_.

Did the mother or father of the patient have any teeth removed because of crowding? \_\_\_\_\_

Does anyone in the family have the same condition? \_\_\_\_\_ Relationship \_\_\_\_\_

Any clicking or pain when opening or closing the jaw? \_\_\_\_\_

Has the patient experienced any unfavorable reaction to medical or dental care? \_\_\_\_\_

Give the date of last dental care: \_\_\_\_\_.

Is there any other information we should know about this patient? \_\_\_\_\_

Please give name, date of birth and age of any and all other children in family:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has there ever been any other family members seen by Dr. Snow? Please give names:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else that you feel Dr. Snow should know regarding this patient?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

It is your obligation to inform us of any health changes.

Signature (of parent, if minor) \_\_\_\_\_

<b>For Office Use Only</b>	Date: _____	Initials: _____
----------------------------	-------------	-----------------