WELCOME

PATIENT INFORMATION

Date _____ ID#/SS# _____

Patient _____

Address _____

_____
City State Zip

Email:_____

Sex: ☐M ☐F Age _____ Birth date _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone (_____)_____

Spouse's Name _____

Birth date _____ SS# _____

Occupation _____

Spouse's Employer _____

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

Subscriber's Name _____

Birth date _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

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

_____
Responsible Party Signature

_____ _____
Relationship Date

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

IN CASE OF EMERGENCY, CONTACT:

NAME _____ Relationship _____

Home (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

DENTAL CONCERNS

Check any of the following which you have at present or are concerned about:

☐ Tooth Sensitivity ☐ Bad Breath ☐ Food Impaction between teeth ☐ Sore or Bleeding Gums

☐ Mouth Ulcerations ☐ Gums, Puffy, Red Swollen ☐ Unpleasant experience form Dental Treatment

☐ Teeth Clenching / Grinding ☐ Loosening Teeth ☐ Not Satisfied with Size, Shape, Color or Appearance of Teeth

☐ Clicking or Popping Jaws ☐ Unpleasant Taste ☐ Missing Teeth ☐ Biting inside of Cheek

☐ Play Contact Sports ☐Sleep Apnea / Snoring ☐ Other Concerns: _____

COSMETIC SMILE ANALYSIS

1. Are your teeth straight? ☐YES ☐NO *Explain*: _____
2. Are there spaces between your front teeth that you dislike? ☐YES ☐NO
3. Are you satisfied with the color of your teeth? ☐YES ☐ NO *Explain*: _____
4. Are you satisfied with the shape of your teeth? ☐ YES ☐ NO *Explain*: _____
5. Are any of your teeth chipped? Hidden? Protruding? ☐YES ☐NO *Explain*: _____
6. Do you have any jagged teeth or teeth that you think are too long or too short? ☐YES ☐ NO
7. Do you have any old fillings or dental work that you think would look much better white? ☐YES ☐ NO
8. Are you satisfied with the way your teeth come together (bite)? ☐YES ☐ NO *Explain*: _____
9. What would you like to change about the appearance of your teeth? _____
10. How would you like your teeth to look? _____