Advanced Dentistry Center

New Patient Information

Dental Insurance

Primary Carrier

Insurance Co. Name_____ Insurance co. Phone_____

Address (Street, City, State, Zip) _____

Group No. (Plan or Policy #) _____Insured's I.D. # _____

Insured's Name _____ Relationship to Pt _____

Date of Birth _____ Insured's Social Security # _____

Insured's Employer Name_____ Is insured a patient in our practice? Yes No

Secondary Carrier

Insurance Co. Name_____ Insurance co. Phone_____

Address (Street, City, State, Zip) _____

Group No. (Plan or Policy #) _____ Insured's I.D. # _____

Insured's Name _____ Relationship to Pt _____

Date of Birth _____ Insured's Social Security # _____

Insured's Employer Name_____ Is insured a patient in our practice? Yes No

Person Financially Responsible for Account

Name _____ Relationship to Patient _____

Social Security No. _____ Phone _____

Driver's License No. _____ Date of Birth _____

Address (Street, City, State, Zip) _____

Employer _____ Work Phone _____

Preferred Method of Payment: Cash Credit Card Check

Visa/MC/AMEX No. _____ Exp. Date_____

If patient is a minor, name of parent or legal guardian and relationship _____

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I herby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes of health or medication.

Signature _____ Date _____

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New Patient Information

Smile Analysis

1. **Do you love that way your smile looks?** Yes No
2. **Do you feel comfortable showing your teeth when you laugh or smile?** Yes No
3. **If you could change anything about your smile, it would be (mark all that apply):**

   Color of Teeth — Too much/too little of teeth shown when smiling

   Gaps between teeth — Size/Shape of teeth

   Too much/too little of gums showing when smiling — Alignment of teeth

   Other: _____.
4. **Do you have (mark all that apply):**

   Sensitive or receding gums — Worn/chipped teeth — Old or discolored fillings

   Missing teeth — Old crowns with dark edges — Other _____.
5. **In your line of work or lifestyle do you (mark all that apply):**

   Visit business or clients — Travel — Speak Publically
6. **If you had a smile makeover do you think you'd feel (mark all that apply):**

   More confident — More optimistic — Healthier

   Just okay — No different — Other _____.
7. **Do you or someone in your family have issues with any of the following:**

   Chronic bad breath — Grinding teeth — Snoring

We'd like to get to know more about you so we can better serve you!

8. **Do you prefer appointments in the (mark all that apply):**

   Morning — Early Afternoon — Late afternoon — Other _____.
9. **Do you have any special events coming up that you'd like us to remember?** _____

   _____.
10. **What types of music do you enjoy?**

    Easy listening — Classical — Rock — Hip-Hop

    Jazz — Country — R&B — Other_____.
11. **What are your favorite hobbies or activities?**

    _____

    _____.
12. **Do have any children or grandchildren? If so, please list their names and ages:** _____

    _____

    _____.
13. **Is there anything else that you want our office to know about you that will help us serve you better?**

    _____

    _____

    _____.

    _____

Signature _____ Date _____