Lee Family Dentistry

About You

Date: _____

Patient Name: _____

What you prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ SS#: _____

Mailing Address: _____

_____

City State Zip

Home Phone #: (___) _____ Work Phone #: (___) _____ Cell Phone #: (___) _____

Email Address: _____ Referred By: _____

Employer: _____

Employer's Address: _____

_____

City State Zip

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouses Name: _____

Do you have children? ☐ Yes ☐ No Names/Age _____

Account Info

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

SS #: _____

Drivers License #: _____

Work Phone #: _____

Primary Dental Insurance Company Name & Phone #

_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am soley responsible for any balance not paid by my insurance company (if offered at this office). _____ intials

Dental Info

Reason for today's visit: _____

Are you in pain? _____

Please indicate any of the following problems:

- ☐ Discomfort, clicking or popping in jaw.
- ☐ Red, swollen, or bleeding gums.
- ☐ Sensitive tooth, teeth or gums.
- ☐ Blisters/Sores in or around the mouth.
- ☐ Lost/Broken Filling(s)
- ☐ Teeth grinding
- ☐ Ringing in Ears
- ☐ Broken/Chipped tooth
- ☐ Stained teeth
- ☐ Locking Jaw
- ☐ Bad breath
- ☐ Other: _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ (___) _____

Name Phone#

Last Dental exam: _____ Last Dental X-rays: _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? _____

Rate your smile 1(worst) to 10(best) _____

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutal understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand that I am responsible for my scheduled appointments. I will reschedule within 24 hours or I will be issued a $50 cancellation fee for a failed appointment.

Signature: _____ ☐ Adult patient ☐ Parent or Guardian ☐ Spouse Date: _____