

Patient Information

Today's Date _____
 Patient Name _____
 Address _____
 City _____
 State _____ Zip _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 E-mail _____
 Preferred phone # to confirm appointments _____
 Sex M F Age _____
 Birthdate _____
 Social Security Number _____
 Married Single Minor
 Occupation _____
 Employer _____
 Address _____

 Emergency Contact _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Spouse's Work _____
 Spouse's Cell _____
 Whom may we thank for referring you? _____
 Who is responsible for this account? _____
 Relationship to Patient _____

Dental Insurance

Insurance Co. _____
 Enrollee ID _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Relationship to Patient _____
 Birthdate _____ Social Security # _____
 Insurance Co. _____
 Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign
 Name of Insurance Company(s)
 directly to **Dr. Sylvan S. Stern D.D.S.** all insurance benefits, any, otherwise payable to me for services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or their benefits payable for related services.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Date

 Relationship to Patient

Dental History

Reason for today's visit _____

 Previous Dentist _____
 City/State _____
 Date of last dental visit _____
 Date of last dental X-rays _____
 Place a mark on "yes" to indicate if you have had any of the following:
 Bad breath Yes
 Bleeding gums Yes
 Blisters on lips/in mouth Yes
 Broken fillings Yes

Burning sensation on tongue Yes
 Cigarette/pipe/cigar smoking Yes
 Clicking or popping jaw Yes
 Dry mouth Yes
 Fingernail biting Yes
 Food collection between teeth Yes
 Grinding teeth Yes
 Growth in mouth Yes
 Gums swollen or tender Yes
 Jaw pain Yes
 Lip or cheek biting Yes
 Loose teeth Yes
 Mouth breathing Yes

Mouth pain Yes
 Orthodontic treatment Yes
 Pain around ear Yes
 Periodontal treatment Yes
 Sensitivity to cold Yes
 Sensitivity to heat Yes
 Sensitivity to sweets Yes
 Sensitivity to biting/chewing Yes
 Sores or growths in your mouth Yes
 Tooth Pain Yes
 How often do you floss? _____
 How often do you brush? _____

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.