Dental WELLNESS OF CLIFTON

We would like to get to know you better!

Date:_____

Name:_____ Prefer to be called:_____ □ Male □ Female

Address:_____ City:_____ State:_____ Zip:_____

Primary Phone:_____ Secondary Phone:_____ Email:_____

DOB:_____ Driver's License:_____ SSN:_____

Marital Status: □ Married □ Single □ Divorced □ Other □ Minor Contact preference: □ Call □ Text □ E-mail

Emergency Contact:_____ Phone:_____ Relationship to patient:_____

Person financially responsible for this account? _____ Relationship:_____

Whom may we thank for referring you to our office? _____

For Insurance Purposes:

Name of Insured:_____ DOB:_____ Relationship to Patient:_____

Dental Insurance Co.:_____ Group #:_____ ID#/SSN:_____

Medical Insurance Co.:_____ Group#_____ ID#:_____

Employer:_____ Occupation:_____ Secondary Coverage? □ Yes □ No

Dental History:

Reason for today's visit?_____ Last dental visit? _____

Have you ever had any serious problems with previous dental treatment?_____

Do you feel discomfort in any of your teeth? _____ Do your teeth bleed when you brush or floss?_____

Do you grind your teeth? Do you have joint/jaw pain? _____ How often do you brush daily? _____ Floss? _____

Please rate your smile: 1 2 3 4 5 6 7 8 9 10 (best) Please rate the color of your teeth: 1 2 3 4 5 6 7 8 9 10 (best)

Any other questions/concerns that have not been covered above? _____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dental Wellness of Clifton all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize Dr. Meytin to perform any necessary examination and radiographs needed for proper diagnosis.

Responsible Party Signature:_____ **Date:**_____ **Relationship:**_____