Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
First Name Middle Initial Last Name

Address _____ City _____ State ____ Zip Code _____

Sex □ M □ F Age ____ Date of Birth _____ □ Single □ Married □ Widowed □ Separated □ Divorced

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____

Email Address _____

Employed by _____ Occupation _____

If full-time student, name of school/college _____ City _____ State _____

Person Responsible for Account _____

Is another member of your family a patient in our practice? □ Yes □ No Is yes, whom? _____

Whom may we thank for referring you? _____

Primary Insurance

Name of Insured _____ Date of Birth _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State ____ Zip Code _____ Phone # _____

Name of Employer _____ Business Phone # _____ Ext. _____

Insurance Company _____

Group # _____ Subscriber # _____

Secondary Insurance

Name of Insured _____ Date of Birth _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State ____ Zip Code _____ Phone # _____

Name of Employer _____ Business Phone # _____ Ext. _____

Insurance Company _____

Group # _____ Subscriber # _____ → **(over)**

Dental History

Name of previous dental office _____

Date of last visit dental visit _____ Date of last dental x-rays _____

How do you feel about the appearance of your teeth? _____

Are your teeth sensitive to: □ Hot □ Cold □ Sweets □ Chewing

Do you feel pain to any of your teeth? □ Yes □ No If yes, please explain: _____

Do you have bleeding gums? □ Yes □ No

Does food or floss get caught between your teeth? □ Yes □ No

How often do you floss? _____ How often do you brush? _____

Have you ever been treated for periodontal disease (gum disease, deep cleaning)? Where _____ When _____

Do you grind or clench your teeth? □ Yes □ No

Do you ever get: □ Neck aches □ Headaches □ Earaches □ Jaw aches □ Clicking or Popping Jaw

Explain: _____

Have you ever had: □ Braces □ Partial or full dentures □ Root canal therapy

Do you have a fear of having dentistry done? □ Yes □ No

Have you had any problems or complications during or following dental treatment? □ Yes □ No

If yes, please explain: _____

_____

We are happy to help you submit the necessary insurance forms; however, we make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be responsible for all charges.

I hereby authorize payment of my insurance benefits directly to Jeremy Berger DDS PLLC (DBA Bluffside Dental). I accept this attending dentist's statement and authorize release of information relating hereto.

I understand that I am financially responsible for all charges whether or not paid by insurance. All accounts over 60 days will be charged 1.5 % interest monthly.

Signature _____ **Date** _____
(insured if different than patient)

Payment is due in full at time of treatment unless prior arrangements have been approved.