WELCOME TO GLADURA DENTAL

Thank you for selecting our practice for your dental care! We would like to thank the person who referred you to us. Please write their name below. If you weren't referred to us by a patient, we would still like to know how you heard about us (Google/Bing/Yahoo search, Facebook/Twitter, Direct Mail, Physician, Outside Sign, Insurance website, or Other.)

_____

Referred by

Patient Information

Date _____ Soc. Security # _____ DOB _____

Name _____ Preferred Name_____

Last Name First Name Initial

Address _____ Email _____

City _____ State/Zip _____

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

Primary Phone: O Cell O Home O Work

Gender: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Student: O Y O N If under 18, Parental Guardian's Name _____

Name of person responsible for account if different from patient _____

Address _____

City, State, Zip _____

Relationship _____ Best phone number _____

Address _____

Emergency contact _____

Name Best Phone Number Relationship

Dental Insurance

_____ _____ _____

Primary Dental Insurance Company Subscriber's Name Subscriber's Soc Sec. #/ID#

_____ _____ _____

Subscriber's Date of Birth Employer Group/Plan Number

Dental History

Do you require antibiotics before dental treatment? O Y O N
Are you currently in pain? O Y O N
Have you ever had gum treatment? O Y O N
Are you aware of popping, clicking or snapping noises when you chew or open/close your mouth? O Y O N
Are you aware of grinding or clenching your teeth? O Y O N

Is there anything about your mouth that concerns you now? _____
_____

Is there anything about your smile you would like to change? _____
_____

How often do you brush?_____ Floss?_____

When was your last dental office visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Does food lodge between your teeth? _____

Do you feel you have unpleasant breath or taste in your mouth? _____

Are you aware of grinding or clenching your teeth? _____

Do you have headaches? _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Gladura 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 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 (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.