Copper Country Family Dentistry P.C.

Name_____ Age_____ Date_____
SS#_____ Birthdate_____ Home Phone_____
Address_____ City_____ State_____ Zip_____
Sex: ☐ M ☐ F Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If a minor, Parent's name(s)_____
Patient's or Parent's Employer_____Work Phone_____
Address_____ City_____ State_____ Zip_____
Spouse's Name_____ Birthdate_____
Spouse's Employer_____ Work Phone_____
Whom may we thank for referring you?_____
Person to contact in case of an emergency:_____ Phone_____

Name of person responsible for this account_____
Address_____ Home Phone_____
Employer_____ Work Phone_____
Relationship to Patient_____ SS#_____

PRIMARY

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#_____ Date Employed_____
Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Contract #_____ Group#_____
Insurance Co. Address_____ City_____ State_____ Zip_____

SECONDARY

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#_____ Date Employed_____
Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Contract #_____ Group#_____
Insurance Co. Address_____ City_____ State_____ Zip_____

Reason for today's visit_____
Former Dentist_____
Address_____ City_____ State_____ Zip_____
Date of last dental visit_____ Last dental cleaning_____ Last dental XRays_____
How often do you brush?_____ How often do you floss?_____

Please check the correct response (Yes, No) to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No	Periodontal Treatment	☐ Yes	☐ No	Sensitive to Sweets	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Orthodontic Treatment	☐ Yes	☐ No	Sensitive when Biting	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No	Oral Surgery	☐ Yes	☐ No	Injury to Mouth or Head	☐ Yes	☐ No
Pain (Joint, Ear, Side of Face)	☐ Yes	☐ No	Sensitive to Cold	☐ Yes	☐ No	Sores/Growths in Mouth	☐ Yes	☐ No
Food Collect Between Teeth	☐ Yes	☐ No	Sensitive to Hot	☐ Yes	☐ No	Loose Teeth/Broken Fillings	☐ Yes	☐ No

Do You:

Chew/Smoke Tobacco?	☐ Yes	☐ No	Are you satisfied with your teeth's appearance?	☐ Yes	☐ No
Clench/Grind Teeth?	☐ Yes	☐ No	Have you ever had complications following dental treatment?	☐ Yes	☐ No
Have Tired Jaws?	☐ Yes	☐ No	Is there anything else about having dental treatment that you would like us to know?	☐ Yes	☐ No
Have Bite Plate/Splint?	☐ Yes	☐ No	DOCTOR'S COMMENTS_____		
Have Mouth Habits?	☐ Yes	☐ No	_____		

(i.e. thumb sucking, nail biting, etc.)

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with_____ and assign directly to Dr. Chalgren all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges AT THE TIME OF SERVICE whether or not paid by insurance. I hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____ Date_____

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