TOZZER DENTAL CARE – INFORMATION FORM

Mr./Mrs./Ms. Patient_____ Birth Date_____
Home Phone_____ Cell Phone_____
Home Address_____
City_____ ST _____ Zip_____
Email_____
SS#:_____ Drivers License#_____ Expires_____
Are You: Single Married Divorced Widowed

Employer: _____ Occupation: _____ Work Phone:_____
Work Address: _____
City: _____ ST _____ Zip_____
Physician_____ City/State_____ Phone_____
Nearest Relative/Friend: _____ Phone_____
Whom may we thank for your referral?: _____

Spouse's Name: _____ Birth Date_____ SS#:_____
Spouse's Employer: _____ Occupation: _____ Work Phone:_____
Work Address: _____
City: _____ ST _____ Zip_____

Do you have Dental Insurance? Yes No

Primary Subscriber_____	Secondary Subscriber:_____
Primary SSN_____	Secondary SSN:_____
Policy/Group#_____	Policy/Group#:_____
Insurance Company_____	Insurance Company:_____
Insurance Address_____	Insurance Address:_____
City/State_____	City/State:_____
Insurance Phone_____	Insurance Phone:_____

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Last X-Rays_____
What are you dental concerns? _____

Do your gums bleed while flossing?	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No
Are your teeth sensitive to sweet or sour?	Yes	No
Do you have any sores or lumps in your mouth?	Yes	No
Have you ever had any head, neck or jaw injuries?	Yes	No
Have you had prolonged bleeding following an extraction?	Yes	No
Do you have dental implants?	Yes	No
Do you like your smile?	Yes	No
Do you have anxieties about your dental treatment?	Yes	No
Would you be interested in Sedation Dentistry?	Yes	No

Have you experienced any of the following problems with your jaw?
Pain Difficulty opening/closing Difficulty Chewing Clicking

I give my consent to dental treatment and the use of necessary local anesthetics, necessary x-rays and nitrous oxide. I understand that responsibility of payment of dental services for my dependents and myself is mine, regardless of insurance involvement, unless prior arrangements are made. Payment is due at the time of service.

_____ Date:_____
Signature – Patient or Responsible Party of Minor.