

## 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.