****

Thank you for putting your trust in **Dental Wellness**. Your smile is the window to your health. We can help keep you smiling.

**ABOUT YOU**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male  Female

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home# (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Work # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other family members who come here for dental care?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_Last visit date: \_\_\_\_\_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DL#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Work # (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABOUT YOUR SMILE

Are you satisfied with the appearance of your smile?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has a Dentist/Hygienist done anything you disliked in the past?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to change about your teeth?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other questions or comments about your dental care?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contacts**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relation: \_\_\_\_\_\_\_\_\_\_\_\_\_

Cell # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_Work #(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neighbor or Relative not living with you**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_Work #(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE**

**Primary Insurance**

Dental Coverage? Yes No

Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Id #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**

Dental Coverage? Yes No

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

**Patients with insurance are responsible for payment of their bills. It is not always possible to predict which services are covered by the carrier or how much they will pay for a particular service.**

**I authorize and request my insurance company to pay directly to Dakota Dental Wellness any insurance benefits otherwise payable to me. I authorize Dental Wellness to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. 1.75% charge will be billed on all accounts 60 days past due. Returned checks will receive a $30 fee. We reserve the right to charge $25 per hour scheduled for cancelled/failed appointments (less than 24 hours notice).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient, Parent or Guardian Date**