Patient Information

Date: ________________

Name:__________________________ Birth Date: ____________ SS#:______________

Street Address:____ / ________
Apt #

______________ / ______ / ____________ E-mail: ______________________________
City State Zip code

Mailing Address:__________________________________ / ______ / ________
City State Zip code

Home Phone:______________ Cell Phone;______________ Work Phone______________

Employer:____

Employer Address:__________________________________ / ______ / ________
City State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Widowed Emergency Contact: ______________________

Relationship:______________________________ Contact Phone:______________

Dental Insurance Information

Are you responsible for this account? ☐ Yes ☐ No If No, name of person who is:______________________

Insurance Co.:______________________________ Group/Policy#:______________

Name of Subscriber:______________________ Subscriber Birth Date:____________ SS#: ____________

Subscriber's Employer: ______________________ Is patient covered by additional insurance? ☐ Yes ☐ No

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with______________________________
(Name of Insurance Company)

And assign directly to Dr. Raymond Carpenter 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 my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative Date

____
Please Print Name of above signature Date

Dental History

How did you hear about our office?______________________________________

Are you under the care of any other dentist? ☐ Yes ☐ No If "Yes" name of dentist:______________________

Do you have your teeth cleaned regularly? ☐ Yes ☐ No Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No

Do you think dental implants would be beneficial for you? ☐ Yes ☐ No

Why are you seeking dental treatment at this time? ______________________________
____

What are the results you would most like to achieve? ______________________________
____

Is there anything else you would like to change about your teeth or smile?______________________
____

Have you ever teeth whitened? ☐ Yes ☐ No Are you interested in teeth whitening? ☐ Yes ☐ No