TLC Dentistry

1 PATIENT INFORMATION (confidential)

Date _____

Patient _____ SS#_____ ☐ Male ☐ Female

Birthdate _____/_____/_____/ Age _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____ City _____ State _____ Zip _____

Home ( ) _____ Work ( ) _____ ext._____ Cell. ( )_____

Email Address _____ Driver License #_____

Patient's Employer _____

Business Address _____ City _____State _____ Zip _____

Spouse's Name _____ Cell Phone _____ Work Phone _____

Person Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

2 *Responsible Party (if other than yourself)*

Name of Responsible Party _____ Relationship to Patient _____

Home Phone _____ Birthdate _____ SS# _____

Address _____City _____ State _____ Zip _____

Employer _____ Work Phone _____

Is this Person currently a patient in our office? ☐ Yes ☐ No Driver's License # _____

3 *Dental Insurance Information*

Policy Holder Name _____ Relation to Patient _____

Birthdate _____ SS# _____

Employer _____

Insurance Company _____ Group _____ Policy ID#_____

Ins. Co. Phone# _____

I, the undersigned certify that I (or my dependent) have insurance with _____and assign directly to Dr. Rawa Hassan 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature Date

4 DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist _____

City/State _____

Previous Dental Problems_____

_____

Date of last dental visit _____

Date of last X-rays _____

Place a Mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Do you grind your teeth ☐ Yes ☐ No

Do you routinely take Analgesics? (Aspirin, Tylenol, Motrin.) ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

Worn teeth ☐ Yes ☐ No

How often do you floss? _____

How often do you brush? _____

Would you like whiter teeth? ☐ Yes ☐ No