

Name of person responsible for your account: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: (____) _____ Work phone #: (____) _____ Employer: _____

Social Security #: _____ Date of Birth: ____/____/____ Marital Status: _____

Why have you come to the dentist today? _____

How would you describe the condition of you teeth and gums: () Good () Fair () Poor

Do your gums bleed when you brush? () Yes () No
 Do your gums bleed when you floss? () Yes () No

Are you currently in pain or discomfort with your teeth or gums? () Yes () No
 If yes please explain: _____

Why did you leave your last dentist? _____

Previous dentists name: _____ Date of last dental visit: _____

Do you have dental insurance? () Yes () No Primary insured's marital status: _____

If yes, who is the primary insured? () Self () Mom () Dad () Spouse () Other _____

Primary insured's date of birth: ____/____/____ Primary insured's SS # ____/____/____

I authorize release of any information relating any dental claim. _____
 Signature

I Authorize release of any insurance benefits for dental treatment in which payment was not rendered at he time of service.

 Signature

Please present your insurance card to the front desk so they can make a copy of it.

I acknowledge that the above information is correct to the best of my knowledge. I understand it will be held in strictest confidence and only be used to improve communication between Dr. Donnelly and myself. I also give my permission for Dr. Donnelly or his staff to use any photos he may take to be used for lecturing or education purposes.

Appointment changes or cancellations must be made a minimum of 2 working days prior to your scheduled appointment time. If notice is not given prior to 2 working days a fee will be assessed to your account. This fee will be 25% of the cost of the scheduled appointment or \$65 whichever is greater.

Signature _____