Welcome to Our Practice

We are pleased to welcome you to our practice.

We look forward to working with you in maintaining your dental health.

Patient Information:

Date:_____ Home Phone (____)_____ Cell Phone (____)_____ Work Phone (___)_____

Name:(last)_____ (first)_____(m.i.)_____ SS#:_____

Address:_____ City:_____State:_____Zip:_____
Sex: (circle one) M F Age:_____ Date of Birth:_____ (circle one) Married Single Minor
Patient Employer/School_____Occupation_____
Employer/School Address_____Employer/School Phone(____)_____
Whom may we thank for referring you?_____
In case of emergency who should be notified?_____Phone(____)_____

Primary Insurance:

Person Responsible for Account_____
Relation to Patient_____ Birthdate_____ID/Soc.Sec.#_____
Address (If different from patient's)_____Phone (____)_____
Person Responsible Employed By_____Occupation_____
Business Address_____Business Phone (____)_____
Insurance Company_____
Insurance Phone#_____Group#_____Subscriber#_____

Secondary Insurance:

Is patient covered by additional insurance? (Please circle one) YES NO If YES, please continue….
Subscriber Name_____Relationship to Patient_____Birthdate_____
Address (If different from patient's) _____Phone (____)_____
Subscriber Employed by_____ Business Phone (____)_____
Insurance Company_____Soc. Sec. #_____
Insurance Phone#_____Group #_____ Subscriber #_____

Dental History:

Reason for Today's Visit_____Date of last dental care_____
Former Dentist_____Date of last dental X-rays_____
Address_____
Circle if you have had problems with any of the following:

Bad Breath	Grinding Teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores or growths in your mouth

How often do your floss?_____How often do you brush?_____

Authorization:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company(ies)
assign directly to Dr. Flaherty and/or Dr. Rossignol all insurance benefits, if any, other wise 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 mentioned dentists 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 remain in effect until I notify this office otherwise.

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

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____ _____
Address if different from patient Phone number Date of Birth

Full payment or insurance co-pay is due in full at time of treatment.