

Patient Information

Whom may we thank for referring you? _____

Patient's Name _____ Today's Date _____

Home Address _____ E-mail _____

City/State _____ Zip _____ Res Tel # _____ Cell _____

Social Security # _____ - _____ - _____ Date of Birth ____/____/____ Age _____ Martial Status S / M / D / W

Your Occupation _____ Employer _____ Bus Tel # _____

Spouses Name _____ DOB ____/____/____ Social Security # _____ - _____ - _____

Your spouse's occupation _____ Employer _____ Bus Tel # _____

Person to contact in emergency _____ Phone # _____ Relationship _____

Bus Tel # _____ Cell Tel # _____ Address _____

Reason for this visit _____

**** Do you have dental insurance? Y / N **** (Please include a copy of your insurance card.)

Name of Insured Person: _____ Policy Holder SSN ____ - ____ - ____ Policy Holder DOB ____/____/____

Employer _____ Employer address _____

Dental Insurance Carrier name _____ Group # _____ Phone # _____

Address to send claims _____

Health History

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL.

Dental History:

Previous Dentist _____ City _____ How long _____

Date of last visit _____ Date of last dental cleaning _____ Date of last full mouth x-ray _____

1. Why did you leave your last dentist? _____

2. What did you like most about any dentist, or a dental office you have been to? _____

3. What did you like least about any dentist, or dental office that you have been to? _____

Check any of the following that you have had or currently have:

- | | | |
|---|--|---|
| <input type="checkbox"/> Mouth Discomfort | <input type="checkbox"/> Pain, Clicking, Popping in Joints | <input type="checkbox"/> Loose or Shifting Teeth |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Trenchmouth or Pyorrhea | <input type="checkbox"/> Mouth Odor or Bad Taste | <input type="checkbox"/> Sensitive Teeth (Hot, Cold, Sweets) |
| <input type="checkbox"/> Gum Abscesses | <input type="checkbox"/> Cold Sores or Fever Blisters | <input type="checkbox"/> Fear of Dental Treatment |
| <input type="checkbox"/> Trouble Chewing/ Speaking | <input type="checkbox"/> Other Oral Lesions | <input type="checkbox"/> Awake with Sore Jaws |
| <input type="checkbox"/> Grind or Clench your teeth | <input type="checkbox"/> Bad Dental Experience | <input type="checkbox"/> Complications with or following previous Dental or Oral Surgical Treatment |
| | <input type="checkbox"/> Immediate Relatives that have lost all of their Natural Teeth | |

Have you ever been concerned about your breath? Yes No

Do you consistently get a bad taste in your mouth? Yes No

Patient Information- Student / Child

Date _____
 Patient's name _____
 Address (local if student) _____

 City/ State/ Zip _____
 Phone hm _____ cell _____
 Email _____
 SSN ____ - ____ - ____ Date of Birth ____/____/____
 Physician's Name _____
 Address _____
 Who may we thank for referring you?

SSN of Mother ____ - ____ - ____
 SSN of Father ____ - ____ - ____
 Birthdate of Mother ____/____/____
 Birthdate of Father ____/____/____

** Do you have dental insurance? ** Y / N
 Name of insured person _____
 Employer _____
 Employer Address _____

Dental Carrier Name _____
 Group # _____
 Address to send claims

 Phone # of company _____

Account Holder Information

Parent's Name and Address

 Parent's home phone _____
 Parent's work phone _____

	YES	NO
1. Are any of your teeth sensitive to: cold, hot, or sweets?	1. _____	_____
2. Are any of your teeth sensitive to biting pressure?	2. _____	_____
3. Have you been told/do you feel you have gum problems?	3. _____	_____
4. Have you had orthodontic treatment (braces)?	4. _____	_____
5. Have you had periodontal treatment (gums)?	5. _____	_____
6. Have you had your wisdom teeth removed?	6. _____	_____
7. Have you had any traumatic injury to the teeth or lower face?	7. _____	_____
8. Have you had your teeth ground or the bite adjusted?	8. _____	_____
9. Have you noticed any loosening of the teeth?	9. _____	_____
10. Does food tend to become caught between your teeth?	10. _____	_____
11. Do your gums often bleed when you clean your teeth?	11. _____	_____
12. Problems of the jaw:	12. _____	_____
a. Pain in join, ear, side of face?	a. _____	_____
b. Clicking or popping when you open or close?	b. _____	_____
c. Difficulty in opening or closing?	c. _____	_____
d. Do you have frequent headaches?	d. _____	_____
e. Do you clench or grind your teeth?	e. _____	_____
13. Do you feel very nervous about dental treatment?	13. _____	_____
14. Have you ever had a bad dental experience?	14. _____	_____
15. Are you unhappy with the appearance of your teeth?	15. _____	_____
16. Do you have frequent mouth ulcers?	16. _____	_____
17. Would you like to use Nitrous Oxide (Laughing gas) during your dental procedure?	17. _____	_____

Name of Previous Dentist _____ Address _____
 Date last visit _____

To Our Patients with a Dental Plan:

Many of our patients have some type of dental benefit plan provided by their employer. With the advent of managed care, HMO's, PPO's, etc, the patient's freedom to choose his/her dentist has been limited, and many dental services are not covered in those plans. With fewer choices of providers on most plans, the patient's access to care has become a major issue in this country. Compromised or limited care is not what we are about with regards to your health. Our focus will always remain on YOU, YOUR needs, and providing the care YOU deserve. It has been our experience that dental insurance plans are very inadequate when patients require comprehensive care. Dental insurance is really not insurance (like health insurance) in that it is only a "supplement" which "assists" you in paying for basic and preventative services.

There are many types of dental insurance coverage options available so it is important that you understand YOUR plan's benefits and limitations. Your best source of information is the benefits representative for your employer. However, don't hesitate to call the insurance company direct. They won't tell us the details of your plan, but YOU are the insured.

It is important not to make health care decisions based on how much your insurance covers nor assume that your dental plan will take care of all your basic needs. This is not always the case, and very often, preventative measures and necessary treatment are postponed.

Some Things You Should Know Regarding Our Insurance Policy:

- We will call your insurance company and get a generalized breakdown of benefits. However, because the insurance company will not guarantee coverage, we can only provide an estimate for you. We encourage you to contact your insurance carrier to clarify plan benefits and limitations as well. You are the policyholder, and it is your right to know your plan benefits. Your employer chose your plan. Our relationship is with directly with you.
- We will be happy to assist you in filing a reimbursement claim to your insurance company. Payment of benefits will be directed to you.
- We are not a contracted provider for any dental insurance plan. We are considered an "out-of-network" provider. However, "out-of-network" does not mean, "not covered"! With the exception of an HMO, your plan *will* provide benefits if you choose us for your dental care, subject to your plans' applicable deductibles and UCR (Usual and Customary) rates.

For 35 years Dr. Birdwell has represented your best interests with dental insurance carriers. He has served on the TDA Council of Legislative and Governmental Affairs lobbying for improved benefit plans for the patients of Texas. He and Dr. Wright are very committed to your dental health and helping you optimize your dental benefits.

If you have any questions, please do not hesitate to call us at 979-776-4843.