Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Bull Mountain FAMILY DENTISTRY

Patient Information

Date: _____

Name: _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State/Zip Code**: _____

Home Phone: _____ **Cell Phone:** _____

Check Option: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate: _____ **Check Option:** ☐ Female ☐ Male **SS#:** _____

Email: _____

Would you like to receive email/text message correspondence (appointment confirmations)?

☐ Yes, I would like to receive text messages ☐ Yes, I would like to receive emails ☐ Neither

If student, name of college: _____ **City/State:** _____ ☐ PT ☐ FT

Patient/ Parent/Guardian's Employer: _____ **Work Phone:** _____

Spouse/Parent/Guardians Name: _____ **Employer:** _____

How did you hear about us? _____

If referred, who should we thank? _____

Emergency Contact: _____ **Phone:** _____

Responsible Party

Name of Responsible for Acct: _____ **Relationship to Patient:** _____

Address: _____ **Home Phone:** _____

Email: _____ **Cell Phone:** _____

Driver's License#: _____ **Birthdate:** _____ **SS#:** _____

Employer: _____ **Is this person currently a patient?** ☐ Yes ☐ No

Insurance Information

Name of Insured: _____ **Relationship to Patient:** _____

Birthdate: _____ **SS#:** _____

Name of Employer: _____ **Work Phone:** _____

Insurance Company: _____ **Group #:** _____

Policy ID#: _____ **Insurance Phone:** _____

Insurance Address: _____ **City:** _____ **State/Zip** _____

Secondary Insurance Information *(complete only if you have additional insurance)*

Name of Insured: _____ **Relationship to Patient:** _____

Birthdate: _____ **SS#:** _____

Name of Employer: _____ **Work Phone:** _____

Insurance Company: _____ **Group #:** _____

Policy ID#: _____ **Insurance Phone:** _____

Insurance Address: _____ **City:** _____ **State/Zip** _____

Dental History

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Does your jaw make noise so that it bothers you or others?	☐	☐
Do your jaws ever feel tired?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Does your jaw get stuck so that you can't openly freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, routine, or activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐
Do you want complete dental care?	☐	☐
How often do you brush?		
How often do you floss?		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize Dr. Nirvana Schuyler to perform any and all approved dental procedures.

Signature of patient (parent or guardian if minor) Date