New Patient Form

Burns Dental Care

Name: Last	First	Middle	Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Address:		City:	State:	Zip:
Email:		Home Phone: *Include area code* ( )	Cell Phone: *Include area code* ( )	
Date of Birth:	SS#:		Sex: M F	
Emergency Contact:	Relationship:	Home Phone: *Include area code* ( )	Cell Phone: *Include area code* ( )	

(Check DK if you Don't Know the answer to the question.)

Dental Information

Please answer the following questions:	**Yes**	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you ever had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

Date of your last dental exam: ____________________

Date of your last dental cleaning: ____________________

Date of your last dental x-rays: ____________________

What is the reason for your dental visit today?

____

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Insurance Information

All information below must be provided below in order for our office to bill your insurance company. Insurance billing is a courtesy we provide to our patients. Please be prepared to provide insurance cards.

Primary Insurance Company: ____________________

Insured Subscriber's Name: ____________________

Subscriber's DOB: ____________________ Employer: ____________________

Insured's SS# or ID#: ____________________ Group #: ____________________

Do you have a secondary insurance? **Yes** ☐ **No** ☐

Authorization of Payment

Authorization For Signature on File

I ____________________, hereby authorize Burns Dental Care to affix my name to any and all claims or documents related to all dental health benefits due to myself and/or my dependents.

I assign to Burns Dental Care all payments for medical/dental services rendered to myself and/or my dependents.

I further authorize Burns Dental Care to furnish insurance carriers, utilization review groups, other physicians, and (if applicable) my attorney any information concerning my teeth and treatment.

A photocopy of these assignments/authorizations shall be valid as the original.

Patient's Signature: ____________________

Printed Name: ____________________ Date: ____________________