

BEST DENTAL CARE CARE NJ

DATE \_\_\_\_\_

SS # \_\_\_\_\_

PATIENT  
NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_

E-  
MAIL \_\_\_\_\_  
\_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
\_\_\_\_\_

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ AGE \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

EMPLOYER NAME, ADDRESS & PHONE NUMBER  
\_\_\_\_\_  
\_\_\_\_\_

SPOUSES  
NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
\_\_\_\_\_

SS# \_\_\_\_\_ SPOUSES  
EMPLOYER \_\_\_\_\_

**DENTAL INSURANCE**

WHO IS RESPONSIBLE FOR THIS  
ACCOUNT? \_\_\_\_\_

RELATIONSHIP TO PATIENT? \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP  
# \_\_\_\_\_

IS PATIENT COVERED BY ADDITIONAL INS \_\_\_\_\_

SUBSCRIBERS NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

GROUP # \_\_\_\_\_

**ASSIGNMENT & RELEASE**

I CERTIFY THAT I, AND/OR MY DEPENDENTS, HAVE INSURANCE COVERAGE WITH (NAME OF INS CO) \_\_\_\_\_ AND ASSIGN DIRECTLY TO DR BEST ALL INSURANCE BENEFITS, IF ANY, OTHERWISE 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-NAMED DENTIST MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAMED INSURANCE COMPANY 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 END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THIS DATE SIGNED BELOW.

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SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

**PHONE NUMBERS**

HOME \_\_\_\_\_ WORK \_\_\_\_\_

SPOUSES WORK \_\_\_\_\_ BEST TIME TO REACH YOU \_\_\_\_\_

**DENTAL HISTORY**

REASON FOR TODAY'S VISIT \_\_\_\_\_

FORMER DENTIST \_\_\_\_\_  
CITY/STATE \_\_\_\_\_

DATE OF LAST DENTAL VISIT \_\_\_\_\_

DATE OF LAST DENTAL X-RAYS \_\_\_\_\_

PLEASE ANSWER QUESTIONS WITH Y OR N

BAD BREATH  
BLEEDING GUMS  
BLISTERS ON LIPS OR MOUTH  
BURNING SENSATION ON TONGUE  
CHEW ON ONE SIDE OF MOUTH  
CIGARETTE, PIPE OR CIGAR SMOKING  
CLICKING OR POPPING JAW  
DRY MOUTH  
FINGERNAIL BITING  
FOOD COLLECTION BETWEEN THE TEETH  
FOREIGN OBJECTS  
GRINDING TEETH  
GUMS SWOLLEN OR TENDER  
JAW PAIN OR TIREDNESS  
LIP OR CHEEK BITING  
LOOSE TEETH OR BROKEN FILLINGS  
MOUTH BREATHING  
MOUTH PAIN, BRUSHING  
ORTHODONTIC TREATMENT  
PAIN AROUND EAR  
PERIODONTAL TREATMENT  
SENSITIVITY TO COLD  
SENSITIVITY TO HEAT  
SENSITIVITY TO COLD  
SENSITIVITY TO SWEETS  
SENSITIVITY WHEN BITING  
SORES OR GROWTHS IN YOUR MOUTH

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_

HOW OFTEN DO YOU FLOSS? \_\_\_\_\_