Welcome to Golden Dental

Patient Information **Date** _____

Social Security Number:_____

Name_____

Address_____

_____

City State Zip Code

Home phone:_____

Cell phone: _____

Sex ☐ M ☐ F

Birthdate:_____ Age_____

☐ Single ☐ Married ☐ Divorced ☐ Seperated

Employment Information

Position_____

Employer_____

Address__ _____

_____

Work phone:_____

How did you hear about our office:

☐ Radio or TV advertisement
☐ Insurance Company
☐ Newspaper advertisement
☐ 800-dentist
☐ Our patient (Name)_____
☐ Other_____

Email Address_____

Responsible Party / Insurance Information

Name: _____

SS Number:_____

Birthdate:_____

Relation to Patient: _____

Insurance Company: _____

Secondary Insurance ☐ Yes ☐ No

Subscribers Name: _____

SS Number:_____

Birthdate:_____

Relation to Patient: _____

Insurance Company:_____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have coverage with _____ and I directly appoint Dr. Markarian/Golden Dental 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 hereby authorize the doctor to release all information necessary to secure the payment of said benefits. In addition I authorize the use of this signature on all insurance submissions.

_____

Signature of Responsible Party

_____

Relation to Patient Date

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____ Phone:_____

PREFERRED PHARMACY INFORMATION:

Name/City:_____ Phone:_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist_____City/State _____

Indicate if you have had any of the following: ☐ Bad breath ☐ Bleeding gums ☐ Blisters on lips or mouth ☐ Burning sensation on tongue ☐ Chew on one side of mouth ☐ Smoking, cigarette or pipe	☐ Clicking or popping jaw ☐ Dry mouth ☐ Fingernail biting ☐ Food collection between teeth ☐ Foreign objects ☐ Grinding teeth ☐ Swollen or tender gums ☐ Jaw pain or tiredness	☐ Lip or cheek biting ☐ Loose or broken teeth ☐ Breathing through your mouth ☐ Pain when brushing ☐ Orthodontic treatment ☐ Pain near or around ear ☐ Periodontal treatment ☐ Sensitivity to cold	☐ Sensitivity to heat ☐ Sensitivity to sweets ☐ Sensitivity when biting ☐ Sores or growths in your mouth How often do you brush?_____ How often do you floss? _____

Date of last dental visit_____Date of last dental X-rays_____