Merrimack Dental Associates

Welcome

SS# _____

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____

Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Address _____City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Driver's License # _____ Birthdate _____ SS# _____

Employer _____ Work Phone _____

Primary Insurance Information

Name of Insured _____ Relationship _____

Birthdate _____ SS# _____Effective Date of Insurance _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone _____ Subscriber ID Number _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No **IF YES, COMPLETE THE FOLLOWING**

Name of Insured _____ Relationship _____

Birthdate _____ SS# _____ Effective Date of Insurance _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone _____ Subscriber ID Number _____

Reason for today's visit _____ Date of last dental care _____

Former dentist _____ Date of last dental X-rays _____

Address _____

Check if you have had any problems with any of the following:

☐ Bad Breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Doctor's Comments _____

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 services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) *Date*