Patient Information

RED DOOR DENTAL

Date_____

Home Phone (_____)_____ Cell Phone (_____)_____ Work (_____)_____

Name _____ E-mail_____
Last Name First Name M.I.

Address _____ SS#_____

City _____ State _____ Zip _____

Sex O M O F Age_____ Birth date_____ O Married O Widowed O Single O Divorced

Patient Employer/School_____ Occupation_____

Emergency contact_____ Phone (_____)_____

Whom may we thank for referring you?_____

Interests/Hobbies_____

Primary Insurance

Person Responsible for Account _____
Last Name First Name M.I.

Relation to Patient_____ Birth date_____ SS#_____

Address (if different from patient's)_____ Phone (_____)_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Is patient covered by additional insurance? O No O Yes Name of Ins. Co. _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

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

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

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

Rate your Smile 1-10 (10 is perfect): 1 2 3 4 5 6 7 8 9 10

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of Insurance Company) and assign directly to Dr. Larsen all insurance benefits, if any, otherwise payable to me for services rendered. 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(ies).

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient