
3725 Wrightsville Ave., Suite A • Wilmington, NC 28403
Phone: (910) 799-9699 • Fax: (910) 792-9987
www.wrightsvilledental.com

TODAY'S DATE_____

PATIENT'S NAME: Last _____ First _____ MI _____ BIRTHDATE _____

Soc. Sec. # _____ Driver's License Number and State _____

Sex: ❑ F ❑ M Marital Status: ❑ M ❑ S ❑ D ❑ W

ADDRESS: Street _____ City _____ State _____ Zip Code _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Adress: _____

Who may we thank for referring you to our office? _____

## DENTAL HISTORY

| | YES | NO |
|---|---|---|
| HOW LONG SINCE you have seen a Dentist? | | |
| Last COMPLETE Dental Exam, Date: Name of Dentist: | | |
| Last FULL MOUTH X-RAYS, Date: (8 Small Films or Panoramic) | | |
| Are you having PROBLEMS now? | ❑ | ❑ |
| IF YES, EXPLAIN: | | |
| On a scale of 1-10 (10 being the highest), what PRIORITY do you give your teeth? 1 2 3 4 5 6 7 8 9 10 | | |
| Do you wear DENTURES? (Partials of Full) | ❑ | ❑ |
| Are you UNHAPPY with your dentures? | ❑ | ❑ |
| Would you like to know more about PERMANENT REPLACEMENTS? | ❑ | ❑ |
| Are you APPREHENSIVE about dental treatment? ❑ YES ❑ NO Do you need Nitrous or Sedation? | ❑ | ❑ |
| Have you had any PERIODONTAL (GUM) treatments? | ❑ | ❑ |
| Do your gums BLEED, or feel TENDER or IRRITATED? | ❑ | ❑ |
| Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle) | ❑ | ❑ |
| Are you UNHAPPY with the APPEARANCE of your teeth? | ❑ | ❑ |
| Are you aware of GRINDING or CLENCHING of your teeth? | ❑ | ❑ |
| Do you have HEADACHES, EARACHES, or NECK PAINS? | ❑ | ❑ |
| Have you worn BRACES on your teeth? (ORTHODONTICS) | ❑ | ❑ |
| Do you have DISCOLORED teeth that bother you? | ❑ | ❑ |
| Would you like your smile to LOOK BETTER or DIFFERENT? | ❑ | ❑ |
| Do you REGULARLY use DENTAL FLOSS? | ❑ | ❑ |
| Do you have RE-OCCURING sores around your mouth? | ❑ | ❑ |
| Have you ever had TROUBLE with previous Dental Treatments? | ❑ | ❑ |
| IF YES, EXPLAIN: | ❑ | ❑ |

# RESPONSIBLE PARTY INFORMATION

NAME: Last _____ First _____ MI _____ MARITAL STATUS: _____

RESIDENCE: Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS: Street _____ Apt. # _____ City _____ State _____ Zip _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SOCIAL SECURITY # _____ BIRTH DATE: _____ DRIVER'S LICENSE #: _____ RELATION TO PATIENT: _____

EMPLOYER: _____

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**RESPONSIBLE PARTY INFORMATION**

NAME: _____

EMPLOYER: _____

SS# _____

WORK PHONE: _____ BIRTH DATE: _____

**DENTAL INSURANCE INFORMATION (Primary Carrier)**

Insured's Name: _____

Insurance Company: _____

Insurance Company Address: _____

Insured's Employer: _____

Insured's Social Security #: _____ Group#: _____

Insured's Date of Birth: _____

**EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.**

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE #: _____

**If you have double dental insurance coverage, complete this for the second coverage.**

Insured's Name: _____

Insurance Company: _____

Insurance Company Address: _____

Insured's Employer: _____

Insured's Social Security #: _____ Group#: _____

Insured's Date of Birth: _____

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## PAYMENT ALTERNATIVES (Please check appropriate box)

❑ 1. Cash and personal checks are accepted as your treatments are provided.

❑ 2. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing you insurance forms and verifying the coverage that your particular program provides. We accept assignments of your insurance payment and will gladly file your claims.*

❑ 3. MasterCard, Visa, American Express, and Discover.

❑ 4. For a long term or extended payments, we offer a healthcare finance program, which when you are accepted, will allow extended small monthly payments for the treatment received.

* *(This means that you are responsible for your deductible and your estimated co-payment at time of treatment. Remember that you are still responsible for the account if the insurance company for any reason does not honor their commitment to you and to us.)*

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*The undersigned hereby authorizes the Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that charges will be added to my account for any overdue balances or returned checks. I also understand that where appropriate, credit reports may be obtained.*

PATIENT Signature (Parent or Child)_____Date:_____

DENTIST Signature:_____