

• Personal Information • (CONFIDENTIAL)

Name: Birth date: SSN: DL#: Home address: City: State: Zip: Home phone: Cell phone: Work phone: Email address: What is the best way to contact you? Home Cell Email Work Other Single Married Partnered Divorced Widowed Employer: Occupation: If student, name of school: Part-time: Full-time: Spouse's name: Birth date: Employer: Occupation: Person responsible for account: Children's names and ages: Whom may we thank for referring you? Previous dentist: Date of last visit: In the event of an emergency, whom should we contact? Phone(s): Relationship

• Insurance Information •

It is our pleasure to prepare the necessary forms to help you obtain your benefits from your insurance company. Each fee is individual for the individual patient. We provide services based on what we believe are best for you.

Primary Dental Insurance Information:

Name of insured: Relationship: Insured's date of birth: SSN: Dental insurance company: Insurance phone: Insurance co. address: Subscriber number: Group number: Employer name:

Secondary Dental Coverage Information:

Name of insured: Relationship: Insured's date of birth: SSN: Dental insurance company: Insurance phone: Insurance co. address: Subscriber number: Group number: Employer name:

I authorize the release of any information concerning my advice and/or treatment provided for the purpose of evaluating and/or administering claims for insurance benefits. I authorize the use of this signature on all insurance submissions and I authorize payment of insurance benefits directly to Dr. Puntillo. I understand that my dental insurance carrier may pay less than the actual bill for services and that I am responsible for payment of services not paid by my insurance provider. I agree that a service charge of 1.5% per month, 18% APR, will be added to balances over 60 days past due. SIGNATURE: DATE:

•Dental History•

1. Please comment about your previous dental experience. _____

2. What are your main concerns? _____

3. How can we help you? _____

•Smile Evaluation•

"Improving lives by designing healthy, beautiful smiles with care and passion."

Do you like the appearance of your teeth? Yes No

Please explain: _____

Are your teeth all in alignment (straight)? Yes No

Please explain: _____

Do you have spaces between your teeth? Yes No

Please explain: _____

Are you happy with the color of your teeth? Yes No

Please explain: _____

Are your teeth chipped? Yes No

Please explain: _____

Are your teeth wearing on the biting surface? Yes No

Please explain: _____

Are you happy with the shape of your teeth? Yes No

Please explain: _____

Do you have missing teeth that you would like to replace? Yes No

Please explain: _____

Do you have old, silver fillings that you would like replaced with tooth-colored fillings? Yes No

Please explain: _____

If you could change anything about your smile, what would you change? _____

