Welcome to Dublin Ranch Dental

Dental history

Reason for leaving last dentist____

Reason for today's visit _______________________________________ Date of last dental care?___________

How did you hear about our office?____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. You probably never thought of these issues. Please check what best expresses how you feel about the following questions:

Tell us in your opinion, what you think the present state of the health of your mouth is? ___________________________

How do you feel about the appearance of your face and smile?____

What do you already know about our office and what are your expectations?

____

What kind of a good dental experience would develop the trust for us to be your dentist?

____

Has the cost of dental treatment been concern for you, and how can we help there? ______________________________

Check ☑ if you have any of the following:

- ☐ Bad breathe
- ☐ Bleeding gums
- ☐ Sensitive teeth
- ☐ Broken fillings/food impaction
- ☐ Clenching/Grinding
- ☐ Jaw pain/popping/clicking
- ☐ loose teeth

How often do you brush and floss?____

Insurance Information

Primary

Name of Insured: ________________________________ ID #_______________________ DOB__________________

Insured's Employer Name: _____________________________________ Group #______________________________

Insurance Plan Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary

Name of Insured: ________________________________ID# ______________________DOB____________________

Inusred's Employer Name: ____________________________________ Group # ______________________________

Insurance Plan Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐Child ☐ Other

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby consent my dentist to take any necessary X-rays, models, and photographs and perform a thorough diagnosis and treatment as needed. I also consent my dentist to perform all recommended treatment mutually agreed upon by us, and use of appropriate medication and therapy indicated for such treatment.

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Patient/Parent/Legal guardian signature **Date**