



Garret Family Dental Care  
 15009 West Bell Road, Suite 175  
 Surprise, Arizona 85374-3213  
 Phone 623.476.8100  
 Fax 623.792.5311  
 garrettdental@gmail.com

## PATIENT INFORMATION

PATIENT NAME \_\_\_\_\_  
 First Middle Initial Last

BIRTH DATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

AGE \_\_\_\_\_ years SEX  Male  Female E-MAIL \_\_\_\_\_

STATUS  Married  Single  Partnered  Minor (Under 18 yrs)  Other \_\_\_\_\_

STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER/SCHOOL OF PATIENT \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

REFERRED BY  Advertisement  Insurance or Discount Plan  Patient(s) \_\_\_\_\_

### PHONE NUMBERS

LIST ONLY THE PHONE NUMBERS THAT YOU WISH US TO CONTACT YOU ON.

PHONE \_\_\_\_\_ Ext \_\_\_\_\_  Mobile  Home  Work  Other

PHONE \_\_\_\_\_ Ext \_\_\_\_\_  Mobile  Home  Work  Other

### EMERGENCY CONTACT

THE FOLLOWING WILL BE CONTACTED (SPECIFY INDIVIDUAL NOT LIVING WITH YOU).

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE \_\_\_\_\_ Ext \_\_\_\_\_  Mobile  Home  Work  Other

### DENTAL HISTORY

REASON FOR TODAY'S VISIT \_\_\_\_\_

FORMER DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF LAST DENTAL VISIT? \_\_\_\_\_ DATE OF LAST DENTAL X-RAYS? \_\_\_\_\_

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_ HOW OFTEN DO YOU FLOSS? \_\_\_\_\_

PLACE A CHECK MARK IF YOU HAVE HAD ANY OF THE FOLLOWING.

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Orthodontic treatment
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Foreign objects in mouth	<input type="checkbox"/> Pain around ear
<input type="checkbox"/> Blisters on lips or mouth	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Periodontal treatment
<input type="checkbox"/> Burning sensation on tongue	<input type="checkbox"/> Gums swollen or tender	<input type="checkbox"/> Sensitivity to cold
<input type="checkbox"/> Chew on one side of mouth	<input type="checkbox"/> Jaw pain or tiredness	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Lip or cheek biting	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Sores/growths in your mouth
<input type="checkbox"/> Fingernail biting	<input type="checkbox"/> Mouth pain, brushing	<input type="checkbox"/> <b>NONE</b>





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## PATIENT INFORMATION

### DENTAL INSURANCE

#### PRIMARY

INSURANCE CO \_\_\_\_\_ PHONE \_\_\_\_\_

GROUP # \_\_\_\_\_ GROUP NAME \_\_\_\_\_

SUBSCRIBER (POLICY HOLDER) \_\_\_\_\_

MEMBER ID (MIGHT BE SS #) \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

PATIENT'S RELATIONSHIP TO SUBSCRIBER  Self  Spouse  Child  Other \_\_\_\_\_

Is the patient covered by additional insurance?  No  Yes (If yes, complete next section)

#### SECONDARY

INSURANCE CO \_\_\_\_\_ PHONE \_\_\_\_\_

GROUP # \_\_\_\_\_ GROUP NAME \_\_\_\_\_

SUBSCRIBER (POLICY HOLDER) \_\_\_\_\_

MEMBER ID (MIGHT BE SS #) \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

PATIENT'S RELATIONSHIP TO SUBSCRIBER  Self  Spouse  Child  Other \_\_\_\_\_

**NO INSURANCE**

#### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company(ies). I assign directly to Garrett Family Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.  
 Dr. Garrett may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining the insurance benefits or the benefits payable for related services. This consent will remain in effect until your relationship with the above named Insurance Company(ies) ends.

**X** \_\_\_\_\_ **Signature of Patient or Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_ **Print name of Patient or Responsible Party** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

### DISCOUNT PLAN

<input type="checkbox"/> Aetna Dental Access	<input type="checkbox"/> Appleton	<input type="checkbox"/> Fourstar	<input type="checkbox"/> UniCare 100/200
<input type="checkbox"/> American Dental Plan	<input type="checkbox"/> Careington POS/500 Series	<input type="checkbox"/> HealthPlus	<input type="checkbox"/> UnitedHealth Allies Plan
<input type="checkbox"/> American Health Benefits	<input type="checkbox"/> Cigna PNA/AHC	<input type="checkbox"/> Savon	<input type="checkbox"/> <b>OTHER</b> _____
<input type="checkbox"/> AmeriPlan	<input type="checkbox"/> DDS – Schedule D	<input type="checkbox"/> Smile Bright	

MEMBER ID # \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

**X** \_\_\_\_\_ **Signature of Patient or Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

