

Welcome to Our Practice...

Mark D. Pratt D.D.S

PATIENT INFORMATION

Patient's Name _____ Mr. Ms. Mrs. Dr. Rev.
 Preferred Name / Nickname _____
 Email Address _____
 Home Phone # _____ Cell Phone # _____
 Sex: Male Female Birthday _____ Single Married † Separated Divorced
 Widowed
 Address _____ City _____ State _____ Zip _____
 Employed By _____ Occupation _____
 Business Address _____
 Business Phone # _____ EXT _____
 Spouse's Name (If Applicable) _____
 Spouse Employed By _____
 Who Is Responsible For This Account? _____
 Relation To Patient (If Applicable) _____
 Account Holders Social Security # _____
 Other Family Members Part of this Practice? _____
 Emergency Contact Name _____ Phone# _____
 Whom May We Thank For Referring You? _____

Dental Benefit Coverage (If Applicable)	Secondary Benefits (If Applicable)
Name Of Insured _____	Name Of Insured _____
Date of Birth _____	Date of Birth _____
Employer _____	Employer _____
Employer's Address _____	Employer's Address _____
_____	_____
Insurance Co Name _____	Insurance Co Name _____
Group # _____	Group # _____
Member ID or Social _____	Member ID or Social _____

GENERAL CONSENT & RELEASE

I, the undersigned, understand that I am responsible for all charges whether or not paid by insurance, if applicable. I may or may not have DENTAL insurance and, if so, assign directly to Dr. Mark Pratt, D.D.S, all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice and treatment to another dentist, dental specialist, or physician.

LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO OR HAD A REACTION TO:

None

List any medications you are currently taking:

None

Are you allergic to:

- Local Anesthetics _____
- Penicillin _____
- Other Antibiotics _____
- Codeine or Other Narcotics _____
- Other Medications _____
- Latex or Metals _____
- Birth Control _____

ARE YOU OR HAVE YOU EVER TAKEN ACTONEL, AREDIA, BONIVA, FOSAMAX, ZOMETA, OR ANY OTHER MEDICATION FOR OSTEOPEROSIS?
YES NO



Purpose of Initial Visit

How long since your last visit? _____

Previous Dentist's Name _____

Please circle THE APPROPRIATE ANSWER.

Have you made regular visits? YES NO

Have you lost any teeth or have any been removed? YES NO

Do you hurt if you clench or grind your teeth? YES NO

Does your jaw click or pop? YES NO

Do you have pain in your jaw or near your ears? YES NO

Do your gums bleed or hurt? YES NO

Have you ever had gum treatment or periodontal surgery? YES NO

Are you unhappy with the appearance of your teeth? YES NO

Have you had any orthodontic treatment? YES NO

Is there anything about dentistry that you strongly dislike? YES NO

Have you ever had any problems or complications with previous dental treatment? YES NO

If yes, explain:

Are any of your teeth sensitive to: Hot Cold Sweets Pressure