Our patients are also our friends. We'd like to get some more information about you so that we can get to know you better.

A B C

Patient Information

Date _____ Age _____ Sex M / F

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Who is your general dentist? _____ E-Mail _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____

Birthdate _____ Social Security # _____

Insurance Co. _____

Group No. _____ Local No. _____

Ins. Co. Address _____

_____

Ins. Phone No. _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO GILBERT H. SNOW, D.D.S. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____
(SIGNED INSURED PERSON) (DATE)

Coverage ____ % ____ Eff. Date _____ Eligibility _____

REMARKS: _____

_____

Do you have dual coverage? Yes ☐ No ☐

If Yes: Insured's Name _____

Birthdate _____ Social Security # _____

Insurance Co. _____

Group No. _____ Local No. _____

Ins. Co. Address _____

_____

Ins. Phone No. _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO GILBERT H. SNOW, D.D.S. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____
(SIGNED INSURED PERSON) (DATE)

Coverage ____ % ____ Eff. Date _____ Eligibility _____

REMARKS: _____

_____

Emergency Information

Name of nearest relative not living with you _____ Phone _____

Complete Address _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

CONFIDENTIAL (for record and pretreatment evaluation)
SNOW-702

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Continued on other side. . .

Is the patient in good health? Yes _____ No _____

Is the patient under the care of a physician?_____

If so, explain_____

Presently taking any medication?_____

If so, explain_____

Does the patient have any history of: (please check yes or no)

Y	N		Y	N		Y	N		Y	N		Y	N		Y	N	
❒	❒	Frequent Colds	❒	❒	Allergies	❒	❒	Dizziness or fainting	❒	❒	Asthma	❒	❒	Aids	❒	❒	Arthritis
❒	❒	Heart trouble	❒	❒	Diabetes	❒	❒	Kidney or liver disease	❒	❒	T.B.	❒	❒	Blood disorders			
❒	❒	Rheumatic fever	❒	❒	Hepatitis	❒	❒	Brain injury	❒	❒	Epilepsy	❒	❒	Hearing difficulties			

❒ or any other disorder. If so, please outline:_____

_____

Have tonsils and adenoids been removed?_____

Have you been on Phen-Fen or Redux? Y ❒ N ❒ If yes, for how long? _____

Please check yes or no if you have ever had any of the following habits:

Y	N		Y	N		Y	N		Y	N		Y	N	
❒	❒	Thumb sucking	❒	❒	Mouth breathing	❒	❒	Grinding of teeth	❒	❒	Tongue biting	❒	❒	Smoking
❒	❒	Nail Biting	❒	❒	Tongue thrusting	❒	❒	Speech disorders	❒	❒	Abnormal breathing			
❒	❒	Tongue sucking	❒	❒	Lip biting									

Approximate age of first tooth:_____.

Did the mother or father of the patient have any teeth removed because of crowding?_____

Does anyone in the family have the same condition?_____Relationship_____

Any clicking or pain when opening or closing the jaw?_____

Has the patient experienced any unfavorable reaction to medical or dental care?_____

Give the date of last dental care:_____.

Is there any other information we should know about this patient?_____

Please give name, date of birth and age of any and all other children in family:

_____

_____

_____

_____

Has there ever been any other family members seen by Dr. Snow? Please give names:

_____

_____

_____

Is there anything else that you feel Dr. Snow should know regarding this patient?

_____

_____

_____

It is your obligation to inform us of any health changes.

Signature (of parent, if minor) _____

For Office Use Only	Date:	Initials: