Oasis Dental Care

Welcome to our Practice

We would like to know you better… Date _____

Name _____ Home (_____)_____-_____ Cell (_____)_____-_____

Adress_____City_____State_____Zip_____

Sex F Date of Birth_____ Social Security#_____-_____-_____

Marital Status Married Spouse's Name_____ Cell (_____)_____-_____

Occupation_____Employer_____ Work (_____)_____-_____

E-mail_____ Emergency Contact_____ Phone(_____) _____-_____

When was your last dental visit?_____ How did you hear about us?_____

Why did you leave your last dentist? Too expensive _____

We want to take care of your concerns and needs first…

What are your present dental problems?_____

Do your gums bleed when brushing? No

Does dental treatment make you nervous? (1-10) 3 - Someti

If I could change my smile, I would make my teeth?_____

For Insurance Purposes…

Insurance name_____ Policy holder_____ D.O.B_____

Policy holder Id # or Social Security#_____Employer_____

Are you covered by another plan?

Insurance name_____ Policy holder_____ D.O.B _____

Policy holder Id # or Social Security#_____ Employer _____

I certify that I, and/or my dependent(s), have insurance coverage with _____

And assign directly to Fu Dental Corp 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. The above named dentist 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 insurance benefits or the benefits payable for related services.

_____

NOTE: Your typed full name will serve as your digital signature.

Signature of patient, parent, guardian

_____ _____

Date Relationship to Patient