

Everyone Loves  
a Gentle Dentist



David H. Leslie D.M.D.

## PATIENT INFORMATION

Name \_\_\_\_\_ Birth date / / \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Cell Phone \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Preferred Method of Contact:

Home Phone       Work Phone       Cell       Text  
 E-Mail \_\_\_\_\_

Sex / Marital Status

Male       Female  
 Married       Single       Widowed

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone( ) \_\_\_\_\_

## RESPONSIBLE PARTY

Name of Person \_\_\_\_\_  
Responsible for this Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone( ) \_\_\_\_\_

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Phone #( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Over

# DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Date of last dental care    /    /                      Date of last dental X-rays                      /    /

Indicate if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> TMJ                            |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to hot             | <input type="checkbox"/> Sleep Apnea                    |
| <input type="checkbox"/> Grinding teeth                    | <input type="checkbox"/> Sensitivity to sweets          | <input type="checkbox"/> Appearance / Smile             |

Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

# CONSENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I hereby grant authority to Dr. Leslie and/or legally qualified auxiliaries to administer treatment, and/or perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of me. I understand I will be consulted before any treatment is rendered.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

# AUTHORIZATION AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and  
Name of Insurance Company(ies)

assign directly to Dr. David H. Leslie 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 an determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**