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:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ TMJ
- ☐ Sleep Apnea
- ☐ 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