# SKYLINE FAMILY DENTISTRY
## Gabriel Overholtzer D.D.S.

PATIENT INFO: Mr. __ Mrs.__ Miss__ PATIENT NAME_____

Social Security #_____ Date of Birth_____ Child__ Single__ Married__ Other__

Address_____ _____State_____ Zip_____

Home #_____ Work #_____ Cell #_____

Emergency Contact _____ Relationship _____ Phone # _____

Patient Employer or School _____ Occupation _____

Drivers License _____ Email Address _____

*HOW DID YOU HEAR ABOUT US?* Referred by _____ Newspaper __ Radio __ Drove by__ Other __

### DENTAL HISTORY

Have you been having any specific problems? ___ YES ___ NO Describe _____

Date of last dental visit _____ Purpose _____ Date of last exam _____

Has fear of discomfort kept you from regular visits? __YES __NO How is your dental health? __GOOD __FAIR __POOR

Do you feel you have decay?__YES __NO Gum Disease __YES __NO Are your gums sensitive & bleed easily? __YES __NO

From your past cleaning visits, what would you say your personal preference is? Gentle___ Medium___Thorough___

How many times a day do you brush? ____ How often do you floss? ____ Do you use a waterPik? ___YES ___NO

How do you feel about your smile? __GOOD __FAIR __POOR What would you like to change about it? _____

Are you interested in whitening your teeth? ___YES ___NO

### PRIMARY INSURANCE INFORMATION/RESPONSIBLE PARTY

Relationship to patient __SELF __SPOUSE __PARENT __OTHER Name of Policy Holder _____

Social Security #_____ Date of Birth_____ Drivers License _____

Address_____ _____State_____ Zip_____

Home #_____ Work #_____ Cell #_____

Emergency Contact _____ Relationship _____ Phone # _____

Patient Employer or School _____ Occupation_____ _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone # _____ Insurance Address _____

### PAYMENT POLICIES

***BALANCES ARE DUE AT THE TIME OF SERVICE. IF YOU ARE INSURED YOU ARE RESPOSIBLE FOR ANY REMAINING BALANCE, ONCE YOUR INSURANCE HAS PAID.*** FEES ARE DETERMINED BY THE SERVICES REQUIRED.

CONSENT FOR SERVICES: I AUTHORIZE THE DR TO PERFORM THE NECESSARY TREATMENT AS NEEDED. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO DENTAL TREATMENT TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PRACTITIONERS FOR MYSELF OR MY DEPENDENTS. I HAVE READ THE ABOVE & AGREE TO THEIR CONTENTS.

**SIGNATURE OF PATIENT, PARENT OR GUARDIAN**_____