

Welcome to Dublin Smiles
Dr. Breanne Bleakmore D.D.S.

How did you hear about our office?
(Please check all that apply)

Friend/Family: _____
Internet Search
Our website
Insurance Company: _____
Other _____

Personal/ Health History of:

Name: _____
Date: _____

Personal Information:

Marital status (please circle one): Married Single

Birthdate: _____

Social Security #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Home Phone: _____

Cell Phone: _____

Work
Phone: _____

Emergency Contact: _____
Phone: _____

Employment Information:

Employer: _____
Do you have dental insurance (please check one)?
Yes
No

If yes, how is it provided?
Through my employer
Through my spouse's employer
Through my family member _____
Through a private provider

Insurance Information:

PLEASE provide your insurance card to receptionist for scanning at each visit:
Insurance Company Name: _____

Group/Employer Name: _____

Member ID/Social SS#: _____

Group Number: _____

Insurance Company Address: _____

Phone # _____ Payor ID: _____

Personal Information of your Spouse:

Name: _____

Address: _____

City: _____ State: _____ Zip _____

Date of Birth: _____

Social Security #: _____

Phone Number: _____

Insurance Information of Your Spouse:

Company Name: _____

Group/Employer Name: _____

Member ID/Social SS# _____

Insurance Company Address: _____

Phone # _____ Payor ID: _____

I hereby authorize any insurance company to pay proceeds of any benefits due me directly to Dublin Smiles. A copy of this can be considered as an original for insurance purposes:

Signature: _____

Date: _____

Dental History:

Are having any dental problems?

Yes

No

If yes, are you having any pain or sensitivity?

Yes Where: _____

No

When was your last dental appointment? _____

What was done at that time? _____