DANIEL I. VARADI DDS PLLC

PATIENT INFO

First Name:_____ Last Name:_____Mid Init:____
Preferred Name:_____ Patient is □ Policy Holder
□ Responsible Party
Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Work Phone:_____Cell Phone:_____
Sex: □ Male □ Female Birthdate:_____ Age:_____
SSN:_____E-mail:_____
□ I would like to receive correspondence via e-mail.
Emer. Contact:_____ Phone Number:_____
Referred By:_____

RESPONSIBLE PARTY INFO
(If different than patient)

First Name:_____ Last Name:_____Mid Init:____
Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Work Phone:_____Cell Phone:_____
Sex: □ Male □ Female Birthdate:_____ Age:_____
SSN:_____E-mail:_____

INSURANCE INFORMATION

Primary Insurance Company:_____
Ins. Co. Address:_____Phone Number:_____
Employer:_____
Are you the employee: □ Yes □ No, Name of employee:_____
Relationship to employee:_____

Yearly Maximum:_____ Remaining Benefits:_____
Secondary Dental Insurance: □ Yes □ No

DENTAL INFORMATION

Last Dental Checkup:_____
Have you ever had:
Ortho Treatment □ Y □ N
Oral surgery □ Y □ N
Periodontal Treatment □ Y □ N
Worn a night guard □ Y □ N

Do you have any dental pain? □ Y □ N
Do you get nervous about dental treatment? □ Y □ N
Do your gums bleed when you brush? □ Y □ N
Does food get stuck in between your teeth? □ Y □ N
Is there pain or swelling of your gums? □ Y □ N
Do you like the appearance of your teeth? □ Y □ N

Secondary Insurance Company:_____
Ins. Co. Address:_____Phone Number:_____
Employer:_____
Are you the employee: □ Yes □ No, Name of employee:_____
Relationship to employee:_____

Yearly Maximum:_____ Remaining Benefits:_____