

REGISTRATION

PATIENT'S NAME _____
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED _____

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

DATE OF BIRTH _____

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

TELEPHONE: RESIDENCE _____

PATIENT/PARENT EMPLOYED BY _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE: BUSINESS _____

PRESENT POSITION _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

SPOUSE BUSINESS TELEPHONE _____

PRESENT POSITION _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

METHOD OF PAYMENT _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

PHONE _____ RELATIONSHIP _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment. If my account becomes delinquent (I have a balance still due 90 days from date of service), I agree that I will be liable for all costs, interest and actual attorney's fees incurred (up to and including 50% of the balance due) in the collection of the balance due. Interest will be added at 1% per month on any account due over thirty (30) days. I agree to a broken appointment charge of at least \$25 for any appointment not cancelled at least 24 hours in advance. I understand that the broken appointment charge may be more based on the time and expertise necessary for the services to be rendered.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

BIRTHDATE _____ RELATION TO PATIENT _____

EMPLOYER _____

ADDRESS _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE: _____

CONTRACT/POLICY # _____

UNION LOCAL OR GROUP # _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE(IF ANY)

EMPLOYEE NAME _____

BIRTHDATE _____ RELATION TO PATIENT _____

EMPLOYER _____

ADDRESS _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE: _____

CONTRACT/POLICY# _____

UNION LOCAL OR GROUP# _____

SOCIAL SECURITY NO. _____

PATIENT OR GUARDIAN'S SIGNATURE _____ DATE _____

DENTAL HISTORY

PATIENT'S NAME _____
Last
First
Initial

CIRCLE THE APPROPRIATE ANSWER

1. Purpose of initial visit _____

2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
6. Have you made regular visits YES NO
 How often? _____
7. Were dental x-rays taken? YES NO
8. Have you lost any teeth? YES NO
9. Have they been replaced? YES NO
10. Were they replaced with a fixed bridge, partial denture, or full denture? YES NO
 Type of replacement _____ Age _____
11. Are you happy with the replacement? YES NO
 If no, explain _____
12. Would you like to know about permanent replacements? YES NO
13. Have you had any problems or complications with previous dental treatment? YES NO
 If yes, explain _____
14. Do you clench or grind your teeth? YES NO
15. Does your jaw click or pop? YES NO
16. Have you experienced any pain or soreness in the muscles of your face? YES NO
17. Do you have frequent headaches, neck aches or earaches? YES NO
18. Does food get caught between your teeth? YES NO
19. Are any of your teeth sensitive to heat, cold, sweets, or pressure? YES NO
20. Do your gums bleed or hurt? YES NO
 When? _____
21. How often do you brush your teeth? _____ When? _____
22. Do you use dental floss? YES NO
 How often? _____
23. Are any of your teeth loose, tipped or shifted? YES NO
24. Have you ever worn braces on your teeth? YES NO
25. Do you have any discolored teeth that bother you? YES NO
26. Do you feel that your breath is offensive at times? YES NO
27. Have you ever had gum treatment or surgery? YES NO
 When? _____
28. Have you had any wisdom teeth removed? YES NO
29. Are you happy with the appearance of your teeth? YES NO
30. Have you had any unpleasant dental experiences? YES NO
31. Do you have any questions or concerns? YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE _____