DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______________________________

SS/HIC/Patient ID # ______________________________

Patient Name ______________________________

Last Name

____

First Name Middle Initial

Address ______________________________

E-mail ______________________________

City ______________________________

State ______________ Zip ______________

Sex ___M ___F Age ______________

Birthdate ______________________________

___Married ___Widowed ___Single

___Minor ___Separated ___Divorce

Patient Employer/School ______________________________

Occupation ______________________________

Employer/School Address ______________________________

____

Employer/School Phone(___) ______________________________

Spouse's Name ______________________________

Birthdate ______________________________

SS # ______________________________

Spouse's Employer ______________________________

Who may we thank for referring you? ______________________________

2 DENTAL INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

Is patient covered by additional insurance __Yes __No

Subscriber's Name ______________________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

INSURANCE AGREEMENT:

The insurance contract is between you and your insurance company .If insurance does not pay our office for services rendered. The balance filed with the insurance is still the responsibility of the patient or parent if a minor. We will file the claim at no charge to you. If within 45 days the insurance has not paid we will consider the balance due from you. You at that time may file with the insurance for reimbursement. If we file the insurance claim for you the assignment of benefits is to the doctor providing the service. We require at least 48 hrs notice of cancellation. If you miss an appointment or don't give 48hrs notice there will be a $50.00 office charge.

____

Signature (parent's signature if minor) Date

3 PHONE NUMBERS

Home ( ) ______________ Work ( ) ______________ Ext____ Cell ( ) ______________

Spouse work ( ) ______________ Best time to reach you ______________

IN CASE OF EMERGENCY, CONTACT (Specified someone who does not live in your household)

Name ______________________________ Relationship ______________________________

Home phone number ( ) ______________ Work phone number( ) ______________

4 DENTAL HISTORY

Reason for today's visit ______________________________

____

Former Dentist ______________________________

City/State ______________________________

Date of last dental visit ______________________________

Date of last dental X-Rays ______________________________

Place a mark on "yes" or "no" to indicate if you have had any of the following

Blisters on lips or mouth ____Yes ____No

Bad breath ____Yes ____No

Bleeding gums ____Yes ____No

Sensitivity to cold, heat, sweets___Yes ___No

Burning sensation on tongue ___Yes ___No

Chew on one side of the mouth ___Yes ___No

Cigarette, or pipe smoking ___Yes ___No

Clicking or popping jaw ___Yes ___No

Dry mouth ___Yes ___No

Gums swollen ___Yes ___No

Jaw pain ___Yes ___No

Loose teeth or broken fillings ___Yes ___No

Mouth pain,brushing ___Yes ___No

Orthodontic treatment ___Yes ___No

How often do you floss ? ______________________________