REGISTRATION

Patient's Name & M.I.____________________Gender M/F Date of Birth__________

Single/Married/Separated/Divorced/Widowed If Child, Parent's Name & M.I.__________________

Address______________________________Zip________Home #__________________

Cell #______________Employer/College________________Business #________________

Patient/Parent Social Security#__________________Spouse's Social Security#________________

Spouse's Name______________Employer________________Spouse Work #______________

Who is responsible for this account?__________Whom may we thank for you coming here?__________

Other family members here____

Driver's License #______________________E-mail Address__________________________

DENTAL INSURANCE 1ST COVERAGE

Insured Name__________________________

Insured Date of Birth___________________

Employer_____________________________

Name of Insurance______________________

Address______________________________

Phone #______________________________

I.D.#________________________________

Group #______________________________

DENTAL INSURANCE 2ND COVERAGE

Insured Name__________________________

Insured Date of Birth___________________

Employer_____________________________

Name of Insurance______________________

Address______________________________

Phone#_______________________________

I.D.#________________________________

Group #______________________________

DENTAL HISTORY

What is your chief dental problem?______________________________________

Previous Dentist's name and phone #_____________________________________

Date of last dental cleaning visit?__________Did you have x-rays?__________Do you smoke?__________

What would YOU like done with your teeth?_________________________________

Do or did you have: toothaches ___ bad breath___ pain in chewing ___ canker sores ___ bleeding gums___
clenching/grinding in day/night___ pain near ears___ other sore areas of mouth___ missing teeth________
braces ___ gum surgery____ bridges/partials/dentures ___ root canal(s)___
How often do you brush?__________ With a hard/soft toothbrush? Do you floss? Y/N/Occasionally

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-I understand that I am responsible for all costs of dental treatment and that patient portions are due on the date of service.
-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 to insurance company(ies) and to another dentist/dental group.
-I hereby authorize payment of insurance benefits directly to the dentist or dental group.
-I attest to the accuracy of the information on this page.

SIGNATURE______________________________________**DATE**__________________