

REGISTRATION HISTORY



PATIENT NAME _____ TODAY'S DATE _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
DATE OF BIRTH _____ SS# _____
PATIENT EMPLOYED BY? _____ POSITION _____ HOW LONG? _____
SPOUSE EMPLOYED BY? _____ POSITION _____ HOW LONG? _____
IN CASE OF EMERGENCY, WHOM DO WE NOTIFY? _____ PHONE _____
WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? _____
MAY WE THANK SOMEONE FOR REFERRING YOU TO OUR OFFICE? _____
OR DID YOU HEAR ABOUT US FROM _____ RADIO _____ NEWSPAPER _____ WEB _____ OTHER _____

- SINGLE
- MARRIED
- WIDOWED
- DIVORCED
- SEPARATED

DENTAL INFORMATION PLEASE PRESENT CARD AT THE FRONT DESK

Name of the Primary Dental Insurance _____	Name of the Secondary Insurance _____
Gr.# _____	Gr.# _____
Employer _____	Employer _____
DOB _____ SS# _____	DOB _____ SS# _____
Insurance ID# _____	Insurance ID# _____
Subscriber _____	Subscriber _____

Our office will gladly bill your Insurance Carrier and Accept Payment. It is the responsibility of our Patient to provide our office with Updated and Current Insurance information.

Date of last dental treatment _____	Do you feel you chew efficiently? _____
Dental service received _____	Do you feel you will eventually lose all you teeth even with proper care? _____
Describe chief dental concern _____	Do any members of your family, including your parents, wear dentures? _____
Why did you leave your last dentist? _____	Are you pleased with the appearance of your teeth? _____
Do you feel discomfort in your teeth when chewing? _____	Are you interested in saving your teeth? _____
Do you feel discomfort in your jaw or joint or in your ear when chewing? _____	Are you deeply concerned about the finances required to return your mouth to excellent dental health, and would you be interested in Financing? _____
Do you have pain, discomfort, sores, or lumps anywhere in your head or neck area? _____	Do you get frustrated because you always have something to be treated or repaired when you visit the dentist? _____
Do you have frequent headaches? _____	If you could change anything about your teeth, as if by magic, what would you change? _____
Do you clench or grind your teeth? _____	
Do your gums bleed when chewing or brushing? _____	
Are you confident in your ability to properly clean your teeth? _____	

FINANCIAL INFORMATION:

This Office requires payment at the time of service. We will bill you Insurance Company and collect your patient portion at the time service is rendered. If you do require Outside Financing we do Provide Care Credit and Capital One Financing Programs. If this is an option for you please ask.

To Avoid a \$50 Broken Appointment/Cancellation Fee a 48 hour notice is required. Please remember this time is reserved especially for you.

Signature: _____ Date: _____