Patient Registration

Date _______________ Patient Name ____

Name you wish to be called ______________________________________

Physical Address ____ Home Phone _________________________

City ______________________ State ______ Zip Code _______________ Work Phone _________________________

E-Mail Address ____ Cell Phone __________________________

Text Confirmation ok? No ☐ Yes ☐

Sex: ☐ M ☐ F Age ________ Birthdate ______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # ____________________________ Employer _____________________________

Who is responsible for this account? ______________________________

****Whom may we thank for referring you? ____**

****

IN CASE OF EMERGENCY PLEASE CONTACT

Name ____ Relationship to you ______________________________

Phone Number _______________________________________

****

Insurance Company ____ Group # ______________

additional insurance? ☐ yes ☐ no Subscriber's name ____

Subscriber's Birthdate ________________ Subscriber's SS or ID# __________________________

Relationship to Patient ____________________________________

Insurance company ____ Group # __________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with

____

and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ __________________________ ______________________

Responsible Party Signature **Relationship** **Date**

DENTAL HISTORY

Reason for today's visit ____

Former Dentist ____________________________________ City/State __________________________

Date of last dental visit ___________________ Date of last dental X-rays _________________________

Please check Yes or No to indicate if you have had any of the following:

Bad breath	[Yes] No	Bleeding gums	[Yes] No	Dry mouth	[Yes] No
Loose teeth	[Yes] No	Broken fillings	[Yes] No	Mouth breathing	[Yes] No
Grinding teeth	[Yes] No	Lip or cheek biting	[Yes] No	Sores or Growths in mouth	[Yes] No
Fingernail biting	[Yes] No	Jaw clicking/popping	[Yes] No	Sensitivity to heat/cold	[Yes] No
Food collection between Teeth	[Yes] No	Pain/discomfort in in jaw joint	[Yes] No	Sensitivity to pressure	[Yes] No
Burning sensation on tongue	[Yes] No	Do you like your smile	[Yes] No	Orthodontic Treatment	[Yes] No
				When:_____________	

How often do you floss ______________

How often do you brush?____________

****

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.
I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

I also give permission for my dentist and dental team to use my photographs for in-office patient education. Initials: _________

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

____ __________________________

Patient's Signature Date

____ __________________________

Doctor's Signature Date

(I have read, agree to, and understand the statements listed above)