MISSION DENTAL

Yang DDS Inc.

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 ˆ Yes ˆ

Sex: ˆ Mˆ ˆ F Age _____Birthdate _____ ˆ Single ˆ Married ˆ Widowed ˆ Separated ˆ 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? ˆ yes ˆ 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

MISSION DENTAL

Yang DDS Inc.

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 When:_____	[Yes] No

How often do you floss _____
How often do you brush?_____

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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)