Patient Information			ental	Insurance	
0		00			
Date		Who is responsible for this account?			
SS/HIC/Patient ID #		Relationship to Patient			
Patient Name		Insurance C	0		
3 a 3 a 4 a 4 a 4 a 4 a 4 a 4 a 4 a 4 a		Group #			
First Name Middle Initial		Is patient covered by additional insurance? Yes No			
Address		Subscriber's	Name_		
E-mail		Birthdate		SS#	
City		Relationship	to Patie	ent	
StateZip		Insurance C	o		
Sex M F Age		Group #			
Birthdate		ASSIGNMEN			
☐ Married ☐ Widowed ☐ Single	Minor			or my dependent(s), have insurar	nce coverage wit
-	for years	N.	ame of Ins	surance Company(ies)	assign directly to
Patient Employer/School	Dr all insurance benefits, any, otherwise payable to me for services rendered. I understand that I an financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.				
Occupation					
Employer/School Address		The above-na	med dent	tist may use my health care informatio	n and may disclos
				above-named Insurance Company(ies) g payment for services and determining	
Employer/School Phone ()		or the benefits	s payable	for related services. This consent will e teted or one year from the date signed	nd when my curre
Spouse's Name		treatment plai	i is compi	eted of one year from the date signed	below.
Birthdate		Signat	ure of Pat	ient, Parent, Guardian or Personal Rep	resentative
SS#		- Diagon prin	t nama at	6 Detient Devent Overdier ex Devend	Danuaratation
Spouse's Employer		Please prin	it name of	f Patient, Parent, Guardian or Personal	Representative
Whom may we thank for referring you?			Date	Relationship t	to Patient
Phone Numbers					
Home ()	Work ()		Ext	Alt. Phone ()	
Spouse's Work ()	Best time and place to re	each you			
N CASE OF EMERGENCY, CONTACT (Specify	someone who does not live	e in your househ	old.)		
Name		Relationship_			
Phone ()		Alt. Phone ()	ie .	
Dental History					
Reason for today's visit	Burning sensation on tor	oguo 🗆 Ves	□No	Mouth breathing	□ Vos. □ No
Todoon for today a visit	Chew on one side of mo		□ No	Mouth pain, brushing	☐ Yes ☐ No
	Cigarette, pipe, or cigar			Orthodontic treatment	Yes No
Former Dentist	Clicking or popping jaw	Yes	☐ No	Pain around ear	☐ Yes ☐ No
City/State	Dry mouth	☐ Yes	□ No	Periodontal treatment	☐ Yes ☐ No
Pate of last dental visit	Fingernail biting Food collection between to	☐ Yes	☐ No	Sensitivity to cold Sensitivity to heat	☐ Yes ☐ No
Date of last dental X-rays	Foreign objects	☐ Yes	□ No	Sensitivity to near	Yes No
Place a mark on "yes" or "no" to indicate if you	Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes ☐ No
nave had any of the following:	Gums swollen or tender	Yes	☐ No	Sores or growths in your mouth	☐ Yes ☐ No
Bad breath ☐ Yes ☐ No	A CONTRACTOR OF THE CONTRACTOR		NIO		
Bleeding gums Yes No	Jaw pain or tiredness Lip or cheek biting	☐ Yes	☐ No	How often do you floss?	

Dental Registration and History