PATIENT REGISTRATION

Patient's name ________________________________Sex: M F Birth date____________ Today's date________

Home address____________________________________City____________________State______Zip__________
Please circle one: Single Married Divorced Widowed Home phone_____________________
Employer______________________ How long________ Work phone_________________ SS#__________________
Cell phone _____________________ E-mail ______________________________________
What is the best way to confirm your appointments: Phone ☐ E-mail ☐
Spouse's name (Parent if minor) ______________________________________
Spouse's birth date ______________________ Spouse's SS# _____________________________
Who may we thank for referring you? ____
Emergency contact – name, address and telephone number of a relative not living with you:
____

DENTAL INSURANCE INFORMATION (Primary carrier)

Insured's name _________________________Insured's birth date _______________Insured's SS#________________

Insured's employer____

Insurance company______________________ Group# _______________Insurance company phone_________________

DENTAL HISTORY

How long since you have seen a dentist? ____

Last complete dental exam date: ____

Last full mouth x- ray date: ____

Are you having problems now? Y N What? ____

Are you APPREHENSIVE about dental treatment? Y N

Have you had PERIODONTAL (gum) treatments? Y N

Do your gums BLEED or feel TENDER or IRRITATED? Y N

Are your teeth SENSITIVE to hot, cold, sweets or pressure? Y N

Are you UNHAPPY with the APPEARANCE of your teeth? Y N

Are you aware of GRINDING or CLENCHING your teeth? Y N

Do you have HEADACHES, EARACHES, or NECK PAIN? Y N

Do you have LOOSE or SHIFTING teeth? Y N

Previous dentist___________________________ City ________________State_____ Phone _________________

Patient signature __________________________ Date________________

The above signed hereby authorizes Dr.s Allen, Clayton, and McLaughlin to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate. I also authorize Dr.s Allen, Clayton, and McLaughlin to perform any and all forms of treatment, medication and therapy. I also understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time service is rendered unless financial arrangements have been made. I also assign all insurance benefits to the doctor. In the event the balance of this account is turned over for collection the above signed will be responsible for collection cost and reasonable attorney's fees.

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