

Family & Cosmetic Gentle Dentistry, LTD

Patient Registration

Patient Name	Preferred Name	Date of Birth	Age
Address	City	State	Zip
Home Phone Number	Social Security Number	Male / Female	

Account Information

Employer	Position/Occupation	Work Phone Number
Spouse's Full Name		Date of Birth
Spouse's Employer	Spouse's Position	Spouse's Work Phone

Insurance Information

Primary Dental Insurance Company _____	Policy Number _____
Name of Policyholder _____	Social Security Number _____
Secondary Dental Insurance Company _____	Policy Number _____
Name of Secondary Policyholder _____	Social Security Number _____
Person Responsible for Account _____	
Address, (If Different From Patient) _____	
In Case of Emergency Please Contact: Name _____	2. In Case of Emergency Please Contact: Name _____
Phone # _____	Phone # _____
How did you learn about our dental practice? Who can we thank for referring you to us?	
Yellow Pages <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> Current Patient <input type="checkbox"/> Name _____	

All the information on both sides of this form is correct to the best of my knowledge. I authorize the administration of any medications and the performance of any procedures that are necessary for my dental care. I am aware that I am financially responsible for all dental care provided. I understand that any consideration on my behalf from a dental insurance company or any third party, is between myself, my employer and the insurance company (companies). I further understand and agree that decisions for dental treatment performed are between the Doctor and myself, regardless of any dental insurance involvement. If the dental fees are not paid as agreed, the under signed shall pay all reasonable attorney and collection fees. I also authorize my insurance benefits to be assigned to Family & cosmetic Gentle Dentistry, LTD.

Patient Signature _____ Date _____

Please Complete The Reverse Side

Health and Dental History

The following confidential information is important for us to know in planning your dental care.
Please answer each question completely

<p>1. When did you last visit a dentist? _____</p> <p>2. Dentist's name and location? _____</p> <p>3. What was done at that time? _____</p> <p>4. Are you satisfied with your past treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>5. How long since your last thorough dental examination? _____</p> <p>6. How often do you have your teeth cleaned/examined? _____</p> <p>7. When were your teeth last cleaned? _____ X-rays taken _____</p> <p>8. Are your teeth sensitive to: Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/></p> <p>9. Do you have any signs of gum disease, bleeding, odor or aches?</p> <p>10. Has fear kept you from regular dental care? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>11. Have you experienced any pain or noise in your jaw joints?</p> <p>12. Are you aware of any swelling or lumps in your mouth?</p>	<p>Comments: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Pressure <input type="checkbox"/> Chewing <input type="checkbox"/> Other _____</p> <p>When/Where _____</p> <p>Explain _____</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Other area _____</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>13. If you could change your teeth, what changes would you change? _____</p>	
<p>14. Would you like your teeth: Straighter? Yes <input type="checkbox"/> No <input type="checkbox"/> Whiter? Yes <input type="checkbox"/> No <input type="checkbox"/> Tooth Colored Fillings? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>15. Do you take pre medication for dental treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>16. What prompted you to seek dental treatment at this time? _____</p>	

Medical History

1. Name of your physician _____	Phone Number _____																																					
2. Location of your physician _____	_____																																					
3. Are you presently being treated for any medical condition? _____	_____																																					
4. Are you allergic to: Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Nickel <input type="checkbox"/> Mercury <input type="checkbox"/>	Other <input type="checkbox"/> _____ None <input type="checkbox"/>																																					
5. Have you ever had a serious illness? Please explain _____	_____																																					
6. What medications and dosages are you presently taking? _____	_____																																					
7. (Women) Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>																																						
8. Do you have, or have you ever had?																																						
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