REGISTRATION HISTORY

GENERAL & IMPLANT DENTISTRY OF WORCESTER COUNTY

PATIENT NAME _____ TODAY'S DATE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ SS# _____

SINGLE ☐
MARRIED ☐
WIDOWED ☐
DIVORCED ☐
SEPARATED ☐

PATIENT EMPLOYED BY? _____ POSITION _____ HOW LONG? _____

SPOUSE EMPLOYED BY? _____ POSITION _____ HOW LONG? _____

IN CASE OF EMERGENCY, WHOM DO WE NOTIFY? _____ PHONE _____

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? _____

MAY WE THANK SOMEONE FOR REFERRING YOU TO OUR OFFICE? _____

OR DID YOU HEAR ABOUT US FROM _____ RADIO _____ NEWSPAPER _____ WEB _____ OTHER

DENTAL INFORMATION PLEASE PRESENT CARD AT THE FRONT DESK

Name of the Primary Dental Insurance

_____

Gr.# _____

Employer _____

DOB _____ SS# _____

Insurance ID# _____

Subscriber _____

Name of the Secondary Insurance

_____

Gr.# _____

Employer _____

DOB _____ SS# _____

Insurance ID# _____

Subscriber _____

Our office will gladly bill your Insurance Carrier and Accept Payment. It is the responsibility of our Patient to provide our office with Updated and Current Insurance information.

Date of last dental treatment _____

Dental service received _____

Describe chief dental concern _____

Why did you leave your last dentist? _____

_____

Do you feel discomfort in your teeth when chewing? _____

Do you feel discomfort in your jaw or joint or in your ear when chewing? _____

Do you have pain, discomfort, sores, or lumps anywhere in your head or neck area? _____

Do you have frequent headaches? _____

Do you clench or grind your teeth? _____

Do your gums bleed when chewing or brushing? _____

Are you confident in your ability to properly clean your teeth?

_____

Do you feel you chew efficiently? _____

Do you feel you will eventually lose all you teeth even with proper care? _____

Do any members of your family, including your parents, wear dentures? _____

Are you pleased with the appearance of your teeth? _____

Are you interested in saving your teeth? _____

Are you deeply concerned about the finances required to return your mouth to excellent dental health, and would you be interested in Financing? _____

Do you get frustrated because you always have something to be treated or repaired when you visit the dentist? _____

If you could change anything about your teeth, as if by magic, what would you change? _____

FINANCIAL INFORMATION:

This Office requires payment at the time of service. We will bill you Insurance Company and collect your patient portion at the time service is rendered. If you do require Outside Financing we do Provide Care Credit and Capital One FinancingPrograms. If this is an option for you please ask.

To Avoid a $50 Broken Appointment/Cancellation Fee a 48 hour notice is required. Please remember this time is reserved especially for you.

Signature: _____ Date: _____