

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION	
Date	_____
Name	_____
SS#	_____
Address	_____
City	_____
State	_____ Zip _____
E-mail	_____
Sex	___ M ___ F
Birthdate	_____
Patient Employer/School	_____
Occupation	_____
Employer/School Address	_____
Employer/School Phone (____)	_____
Marital Status	_____
Spouse's Name	_____
Birthdate	_____
SS#	_____
Spouse's Employer	_____
Whom may we thank for referring you?	_____

DENTAL INSURANCE	
Person Responsible for Account	_____
Relationship to Patient	_____
Insurance Co.	_____
Group #	_____
Is patient covered by additional insurance?	_____
Subscriber's Name	_____
Birthdate	_____ SS # _____
Relationship to Patient	_____
Insurance Co.	_____
Group #	_____
ASSIGNMENT AND RELEASE	
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Haigler/Greenwood Dental Associates, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.	
Greenwood Dental Associates, PA may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for their services and determining insurance benefits or the benefits payable for related services.	
Signature	_____
Print Name	_____
Date	_____ Relationship to Patient _____

PHONE NUMBERS	
Home (____) _____	Work (____) _____ Ext _____ Cell Phone (____) _____
Spouse's Work (____) _____	Best time and place to reach you _____
EMERGENCY CONTACT	
Name _____	Relationship _____
Home phone (____) _____	Work Phone (____) _____

DENTAL HISTORY	
Reason for today's visit _____	Check if you have had any of the following:
Former Dentist _____	___ Bad breath
City/State _____	___ Bleeding gums
Date of last dental visit _____	___ Blisters on lips or mouth
Date of last dental X-rays _____	___ Food collection between teeth
How often do you brush? _____	___ Grinding teeth
How often do you floss? _____	___ Gums swollen or tender
	___ Jaw pain
	___ Lip or cheek biting
	___ Loose teeth or broken fillings
	___ Mouth Breathing
	___ Orthodontic Treatment
	___ Pain when brushing
	___ Periodontal treatment
	___ Sensitivity to cold
	___ Sensitivity to hot
	___ Sensitivity to sweets
	___ Sensitivity when biting
	___ Sores or growths in your mouth

