Mansfield Family Dentistry Medical and Dental Registration History

PATIENT INFORMATION

Date _____

Patient Name _____

Preferred Name _____

Address_____

_____

City_____ Zip_____

Phone Home _____

Cell _____

Work _____ Ext_____

Sex ○ Male Date of Birth _____

○ Female SS# _____

○ Married ○ Single ○ Divorced ○ Widowed

E-Mail _____

Preferred method of contact ○ Call ○ Text ○ Email

How did you hear about us? _____

DENTAL INSURANCE

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to patient _____

Employer _____

Insurance Co _____

Policy ID # _____

Group# _____

Does patient have secondary insurance? ○ Yes ○ No

Subscriber Name _____

Birthdate _____SS# _____

Relationship to patient _____

Employer _____

Insurance Co _____

Policy ID # _____

Group # _____

EMERGENCY NUMBER

Name _____

Relationship to patient _____

Phone Home _____

Cell _____

Work _____

ASSIGMENT AND RELEASE

Payment is due at time of treatment

If this office accepts insurance, I understand that I am responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to Mansfield Family Dentistry of the group insurance benefits. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of my information to my insurance company for billing.

_____/_____

Signature of Patient/Guardian Date

Reason for today's visit _____

_____

Place a mark on "yes" or "No" to indicate if you have had any of the Following:

Problems following dental treatment	○ Yes	○ No
Reaction to local anesthetic	○ Yes	○ No
Severe injury to face, teeth or jaw	○ Yes	○ No
Surgery to mouth of face	○ Yes	○ No
Bad breath/Bleeding gums	○ Yes	○ No
Dry Mouth	○ Yes	○ No
Periodontal Treatment	○ Yes	○ No
Tooth sensitivity hot/cold	○ Yes	○ No
Jaw pain/tenderness	○ Yes	○ No
Teeth Clenching/grinding	○ Yes	○ No
Jaw click or pop/difficult opening	○ Yes	○ No
Worn of have a night guard	○ Yes	○ No
Orthodontic treatment	○ Yes	○ No
Use of any tobacco products	○ Yes	○ No
Do you snore	○ Yes	○ No

Date of last dental visit _____

How often do you brush _____Floss _____

Satisfied with appearance of your teeth ○ Yes ○ No