Patient Registration

Patient Information

Name: Last_____ First _____ Middle Initial_____

Today's Date: _____ Sex: M F Birth date: _____/_____/_____

Age: _____ S.S.# _____ Email: _____

Home Phone_____ Alternative Phone_____

If patient is a minor, give Parent or Guardian's name_____

Home address: Street_____ Apt. #_____

City_____ State_____ Zip Code_____

How long at this address? _____

Previous Address (if less than 3 yrs.) Street_____ Apt. #_____

City_____ State_____ Zip Code_____

Whom may we thank for referring you to us? _____

Responsible Party Information

Name: Last_____ First_____ Middle Initial_____

S.S.# _____ Driver's License Number_____

Birth Date _____/_____/_____ Marital Status _____ Relation to Patient_____

Home address: Street_____ Apt. #_____

City_____ State_____ Zip Code_____

Home Phone_____ Alternative Phone_____

Employer_____ Occupation_____ Yrs. Employed_____

Responsible Party's Spouse

Name: Last_____ First_____ Middle Initial_____

Employer_____ Occupation_____ Yrs. Employed_____

S.S.# _____ Birth Date _____/_____/_____

Home Phone_____ Alternative Phone_____

Emergency Information (Relative not living with you)

Name _____ Relationship _____

Address _____

City, State _____ Phone _____

Dental Insurance Information

Subscriber's Name _____ Insurance Co. _____

Insurance Company Address _____

Insured's Employer _____ Subscriber's Date of Birth _____

Subscriber's S.S.#_____ Group #_____

Subscriber # _____ Local #_____

If you have double dental insurance coverage, complete this for the second coverage.

Subscriber's Name _____ Insurance Co. _____

Insurance Company Address _____

Insured's Employer _____ Subscriber's Date of Birth _____

Subscriber's S.S.#_____ Group #_____

Subscriber # _____ Local #_____

Upon scheduling, the undersigned herby authorizes Dr. Jay Harris Levy and/or his staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs, and to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me, if I have paid the dental fees incurred. I further understand that a late charge of $10.00 per month will be added to any over due balance. I understand that where appropriate, credit reports may be obtained.

Patient signature (Parent of Minor)_____ Date_____

Dental History

Name of Previous Dentist_____

City_____ State _____ Zip_____

What are your chief concerns? _____

Please rank the following (1 being the least and 4 most) in the order in which they would keep you from having dental treatment.

Fear of Pain _____Lack of Concern_____Cost of Treatment_____Missing Work_____

Have you had any trouble associated with previous dental treatment? _____

_____

_____

How long since you have seen a dentist? _____

Date of last complete dental exam _____

Date of last full mouth X-rays (18 films) _____

Do you wear dentures (full or partial)?	Yes	No
Are you happy with your dentures?	Yes	No
Would you like to know more about permanent replacements?	Yes	No
Are you apprehensive about dental treatment?	Yes	No
Have you had any periodontal (gum) treatment?	Yes	No
Do your gums bleed, or feel tender, or irritated?	Yes	No
Are you happy with the appearance of your teeth?	Yes	No
Are you aware of grinding or clenching your teeth?	Yes	No
Do you have headaches, earaches, or neck pains?	Yes	No
Have you had braces on your teeth (orthodontics)?	Yes	No
Do you have discolored teeth that bother you?	Yes	No
Would you like your smile to look different or better?	Yes	No

How often do you brush your teeth?_____ How often do you floss your teeth?_____

Patient signature (Parent of Minor)_____ Date_____