DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION Date ShriCPatient ID # Patient Name Lest Name Fit Name Middle initial Addrines E-mail Addrines ShriChard Name Lest Name Fit Name Middle initial Addrines ShriChard Name ShriChard Name ShriChard Name Lest Name Fit Name Middle initial Addrines ShriChard Name Sh						
Relationship to Patient Patient Name	PATIENT INFORMATI	ON Z	J DENTA	AL INSURANCE		
Insurance Co.	Date		Who is responsible for this account?			
First Name	SS/HIC/Patient ID #		Relationship to Patient			
First Name	Patient Name		Insurance Co.			
Address Subscriber's Name Birthdate SS4 Relationship to Patient Single Minor Separated Divorced Partnered foryears AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent(s), have insurance coverage with AssiGMMENT AND RELEASE Certly final I, and/or my dependent on the above-named dentities of the province of definition and may disclose such information to the above-named dentities of the use of my dependent on the above-named dentities of the use of my dependent on the definition of the definition of Patient AssiGMMENT AND RELEASE Certly final I, and the agents of the use of my dependent on the definition of Patient AssiGMMENT AND RELEASE Certly final I, and definition of Patient AssiGMMENT AND RELEASE Certly final I, and definition of Patient AssiGMMENT AND RELEASE Certly final I, and definition in the insurance coverage with AssiGMMENT AND RELEASE Certly final I, and definition in the insurance coverage with AssiGMMENT	Last Name	Gro	oup #			
Address	First Name	Middle Initial Is r	patient covered by	/ additional insurance? ☐ Yes	□No	
Birthdate	Address					
Relationship to Patient	E-mail					
State		I 1				
Sex M F Age						
ASSIGNMENT AND RELEASE certify that it, and/or my dependent(e), have insurance coverage with married widowed Singlo minor separated movement moveme						
Married Wildowed Single Milmor Separated Divorced Partnered for years Patient Employer/School Partnered for years Patient Employer/School Partnered for years Dr. Aumo of Insurance Company(es) and assign directly to Dr. Aumo of Insurance Company(es) Dr. D		44 mg - 19				
Separated Divorced Patrnered foryears Patrnered Patrnered Patrnered foryears Dr	I certify that I and/or my dependent(s) have insurance coverage with					
Patient Employer/School	and assign directly to					
Occupation	Separated Divorced Partnered for years Name of Insurance Company(ies)					
Employer/School Address	any otherwise payable to me for services rendered 1 understand that 1 am					
The above-named dentist may use my heath care information and may disclose such information to the above-named insurance Company(se) and their agents for the purpose of obtaining insurance such information to the above-named insurance Company(se) and their agents for the purpose of obtaining insurance benefits or the benefits payeble for related services. This consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consent will end when my current treatment plan is consentative. Signature of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Signature of Patient,	Occupation	fina	financially responsible for all charges whether or not paid by insurance. I authorize			
Employer/School Phone ()	Employer/School Address					
Employer/School Phone () banefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. Birthdate	such information to the above-named Insurance Company(ies) and their ager					
Signature of Patient, Parent, Guardian or Personal Representative	Employer/School Phone ()	benefits or the benefits payable for related services. This consent will end when				
Spouse's Employer	Spouse's Name	my	current treatment p	an is completed or one year from the	date signed below.	
Please print name of Patient, Parent, Guardian or Personal Representative Whom may we thank for referring you? Date Relationship to Patient Phone Work Ext Cell Spouse's Work Best time and place to reach you IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) Name	BirthdateSignature of Patient, Parent, Guardian or Personal Representative					
Date Relationship to Patient						
PHONE NUMBERS Phone	Please print name of Patient, Parent, Guardian or Personal Representative					
Phone (Whom may we thank for referring you? Date Relationship to Patient					
Phone (
Phone (PHONE NUMBERS					
Best time and place to reach you			· · · · · · · · · · · · · · · · · · ·	· · ·		
Name						
Name						
No Nouth peathing Yes No No Nouth pain, brushing Yes No No No Nouth pain, brushing Yes No No No No No No No N						
DENTAL HISTORY Reason for today's visit						
Reason for today's visit	Home Phone ()	Work F	Phone ()_			
Reason for today's visit	The state of the s	÷				
Chew on one side of mouth	DENTAL HISTORY	- W- W	+ 			
Cigarette, pipe, or cigar smoking	Reason for today's visit	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	
City/State				1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971 - 1971		
City/State Dry mouth	Former Dentist					
Date of last dental visit	City/State		Acceptant Continue			
Date of last dental X-rays Food collection between the feeth Yes No No	Date of last dental visit			SWM DESCRIPTION OF WE ARE TO	Service and Control of the Control o	
Place a mark on "yes" or "no" to indicate if you have had any of the following: Grinding teeth Yes No Sensitivity when biting Yes No Sores or growths in your mouth Yes No				2004 OF 10 AT 10		
have had any of the following: Gums swollen or tender Yes No Sores or growths in your mouth Yes No		***		385V	5.5 S.	
				(3) 1=0		
How often do you floss?	Bad breath Yes No	Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss?		
Bleeding gums	ATTENDED OF THE PROPERTY OF TH	to the same again to the same and the same against the sa				