LOUISVILLE FAMILY & COSMETIC DENTISTRY

Patient registration

Patient information

Date_____

Social security #_____

Patient name Last_____

First _____

Middle_____

Address_____

City_____

State_____**Zip**_____

Sex □F □M

Date of Birth_____

□single □married □child □other

Patient employer/school_____

Occupation_____

E-Mail Address _____

Spouse's name_____

Spouse's employer_____

Spouse's date of birth_____

Contact information

Home#(_____)_____**Work#(_____)**_____

Cell#(_____)_____

In case of emergency, contact (someone not in your household)

Name_____

Home#(_____)_____**Work#(_____)**_____

Relationship_____

Insurance information

Who is responsible for this account?_____

Relationship to patient_____

If responsible party has different address

_____

_____

Patient's dental insurance company

_____

Group #_____

Subscriber's name _____

Subcriber's employer_____

Subscriber's date of birth_____

Subscriber's social security #_____

Is the patient covered by additional insurance?

□yes □no

If additional insurance-

Secondary insurance Co._____

Group #_____

Subscriber's name_____

Subcriber's employer_____

Subscriber's social security #_____

I certify that I, and/or my dependent(s), have insurance coverage with

_____

and assign directly to Dr. Sarah Willett Ecken all insurance benefits, 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.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance co. and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____

Signature of patient **date**

Dental History

Reason for today's visit_____

Former Dentist_____Date of last dental visit_____

Date of last dental x-rays_____How often do you floss?_____Brush?_____

Please check "yes" or "no" next to each:

Bleeding gums	□yes □no	Swollen or tender gums	□yes □no
Bad breath	□yes □no	Sensitivity to hot &/or cold	□yes □no
Cigarette, pipe, or cigar smoking	□yes □no	Sensitivity to biting	□yes □no
Dry mouth	□yes □no	Periodontal treatment	□yes □no
Smokeless tobacco use	□yes □no	Loose teeth	□yes □no
Grind teeth	□yes □no	Jaw pain or tiredness	□yes □no

Referred by □ insurance □ friend/family _____ □ mailer □ other_____