DENTAL REGISTRATION AND HISTORY

301 N Pine St, Spartanburg, SC 29301
864-583-7473

2830 Reidville Rd, Spartanburg, SC 29301
864-574-0762

Date ______________________ Home Phone ____________________________ Cell Phone _______________________

PATIENT INFORMATION

Name ____ SS# ___________________________________

Address ____ E-mail ____

City ____ State _______________ Zip ______________________

Sex M F Age ________ Birth Date ________________ Marital Status: ___________________________

Patient Employer/School _______________________________________ Occupation _____________________________

Employer/School Address ______________________________________ Employer/School Phone (_______) ______________

Whom may we thank for referring you? ____

PRIMARY INSURANCE

Person Responsible for Account ____

Relation to Patient ________________________ Birth Date ________________ Soc Sec #_________________________

Address (if different from patient) ________________________________ Phone (_______) _______________________

City ____ State _______________ Zip ______________________

Person Responsible Employed by _________________________________ Occupation _____________________________

Business Address ____ Business Phone (_______) ____________________

Insurance Company ____ ID # __________________________________

Group # _________________________________ Subscriber # _____________________________

SECONDARY INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _________________________ Birth Date ________________ Relation to Patient ___________________

Address (if different from patient) ________________________________ Phone (_______) _______________________

City ____ State _______________ Zip ______________________

Subscriber Employed by _______________________________________ Business Phone (_______) ____________________

Insurance Company ____ Soc Sec # ______________________________

ID # ________________________________ Group # ___________________ Subscriber # ______________________

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s), have insurance coverage with __________________________ and assign directly to Foothills Dental 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. The above-named doctor/practice 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 services and determining insurance benefits or the benefits payable for related services.

____ _________________________________

Signature of Patient, Guardian, or Personal Representative Date

____ _________________________________

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

DENTAL HISTORY

Reason for Today's Visit ____

Date of last dental care ____________________ Date of last dental X-rays ____________________

Former Dentist ____________________ Address ________________________________

Please CIRCLE if you have had problems with any of the following

Bad breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores or growths in your mouth

How often do you floss? ______________ How often do you brush? ____________________

EMERGENCY CONTACT

Emergency Contact __________________________ Phone Number ____________________

Relationship to Patient ____________________

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____________________________________ Date ____________________