

Date \_\_\_\_\_

**J. Brad Tally, D.D.S.**  
**Aaron M. Craig, D.D.S.**

### Patient Registration

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home # \_\_\_\_\_ Work # \_\_\_\_\_ ext. \_\_\_\_\_ Cellular # \_\_\_\_\_

E-mail Address \_\_\_\_\_

Sex:  Male  Female      Marital Status:  Single  Married  Separated  Divorced  Widowed

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Referred By \_\_\_\_\_

### Financial Responsibility

Person Financially Responsible \_\_\_\_\_ Relationship \_\_\_\_\_

Address of Responsible Party (if different from above) \_\_\_\_\_

Dental Insurance  Yes  No      Group/Employer Sponsored Policy  Yes  No

Name of Subscriber \_\_\_\_\_ Subscriber's Soc. Security # \_\_\_\_\_

Birth Date \_\_\_\_\_ Employer \_\_\_\_\_

Name of Primary Dental Insurance \_\_\_\_\_ Group Plan # \_\_\_\_\_

Secondary Dental Insurance  Yes  No      Group/Employer Sponsored Policy  Yes  No

Name of Subscriber \_\_\_\_\_ Subscriber's Soc. Security # \_\_\_\_\_

Birth Date \_\_\_\_\_ Employer \_\_\_\_\_

Name of Secondary Dental Insurance \_\_\_\_\_ Group Plan # \_\_\_\_\_

### Dental History

Reason for today's visit? \_\_\_\_\_

Last visit to a dentist? \_\_\_\_\_ What was the visit for? \_\_\_\_\_

Have you ever had a serious problem associated with previous dental treatment (i.e. tooth extraction)? \_\_\_\_\_

If so explain \_\_\_\_\_

How often do you brush? \_\_\_\_\_ floss? \_\_\_\_\_ other? \_\_\_\_\_

Do your gums bleed while brushing? \_\_\_\_\_ or flossing? \_\_\_\_\_

Are your teeth sensitive to hot, cold, or pressure? \_\_\_\_\_

Do you clench or grind your teeth during the day? \_\_\_\_\_ while sleeping? \_\_\_\_\_

Do your jaws click or pop when eating or speaking? \_\_\_\_\_

Are there any concerns about the way your teeth look? \_\_\_\_\_

### Authorization and Release

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any dental group insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than actual fee for services. I agree to be responsible for payment of all services rendered for myself and any of my dependents.*

\_\_\_\_\_  
*Signature of Patient (or parent/guardian of minor child)*