J. BRAD TALLY, DDS
AARON M. CRAIG, DDS

Date _____

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)