PATIENT REGISTRATION

PATIENT INFORMATION

First Name: ______________ Last Name: ___________________ Preferred Name:______________
Address: ____
City: ______________________________________ State: _________ Zip Code: _______________
Home Phone: _________________ Work No. __________________ Cell. No. __________________
Sex: M F Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date: _________________ Age: ______ SSN: ___________________ DL#: _______________
E-mail: _________________________________ ☐ *I would like to receive correspondences via e-mail*
How did you hear about our office? ______________ Previous Dentist: _______________________
Emergency Contact: ________________________________ Emerg. Contact #: ________________
Relation to Patient: ________________________________

INSURANCE INFORMATION

DENTAL INSURANCE
Carrier Name: _________________________
Subscriber: ___________________________
Relation to Subscriber: ☐ Self ☐ Spouse ☐ Other
Subscriber ID: _________________________
Subscr. DOB: ____________Group # _________

MEDICAL INSURANCE PPO HMO
Carrier Name: _________________________
Subscriber: ___________________________
Relation to Subscriber: ☐ Self ☐ Spouse ☐ Other
Subscriber ID: _________________________
Subscr. DOB: ____________

QUESTIONNAIRE

If I could change my smile, I would;

- ☐ Make them brighter (Deep Bleaching)
- ☐ Make them straighter (6 month smile, Invisalign)
- ☐ Close spaces
- ☐ Replace silver filling with natural, tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth (Implant or Bridge)
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating;

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

What prompted you to seek dental care at this time?
____
What is the most important thing that we can do for you?
____
What are some of your favorite hobbies?
____

AUTHORIZATION FOR DENTAL TREATMENT & RELEASE OF INSURANCE INFORMATION

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment. I assign all dental, medical and surgical benefits, including major medical benefits to which I am entitled, to Julia Lee, DDS, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I authorize and give consent to Dr. Julia Lee and staff to perform dental treatment, including but not limited to, local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient. I understand that my photos may be used for teaching or sharing purposes. I understand that I am financially responsible for charges whether or not paid by insurance.

Patient Signature: ____ Date: ____________________

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