QUARTERPATH DENTAL CENTER
PATIENT REGISTRATION
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX M F

ADDRESS _____CITY/STATE_____ZIP_____

HOME PHONE _____ CELL PHONE _____WORK PHONE_____

EMAIL_____ MARITAL STATUS: S M D W

EMPLOYER: _____

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): Self Spouse Child Other

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

ADDRESS _____CITY/STATE_____ZIP_____

DATE OF BIRTH _____ HOME PHONE _____ WORK PHONE _____EXT_____

EMPLOYER _____

DENTAL HISTORY

CURRENT GENERAL DENTIST _____

DATE OF LAST DENTAL VISIT _____ LAST DENTAL CLEANING _____ LAST FULL MOUTH X-RAYS _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____Seldom _____ Less than annually _____ Annually _____ Twice Annually or More

HOW OFTEN DO YOU BRUSH YOU TEETH? _____ HOW OFTEN DO YOU FLOSS? _____

WHAT OTHER DENTAL AIDS DO YOU USE? (Mouthrinse, toothpick, etc.) _____

Have you ever had:

Periodontal Treatment (deep cleaning or gum surgery)?	Yes No……. If yes, when? _____
Oral Surgery (tooth removal)?	Yes No
Orthodontic Treatment (braces)?	Yes No ……. If yes, when? _____
Your teeth ground or the bite adjusted?	Yes No
A bite plate or mouth guard?	Yes No
Do you smoke or chew tobacco?	Yes No……. If yes, how much? _____
Do you clench or grind your teeth while awake or asleep?	Yes No
Has any of your family members experienced periodontal disease (such as gum disease or gingivitis)?	Yes No…….If yes, which family members? _____
Have you noticed any loose teeth or a change in your bite?	Yes No _____
Do you mouth-breathe while awake or asleep?	Yes No
Does food tend to become caught in between your teeth?.	Yes No……. If yes, where? _____
Do you have tired jaws, especially in the morning?	Yes No _____
Do you regularly experience clicking, popping or pain in the jaw joints?	Yes No
Do you have difficulty in opening or closing your mouth?	Yes No

Do you chew on objects such as pencils or bite your nails? Yes No……. If yes, what objects? _____

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No……. If yes, what is your main concern? _____

_____

Have you ever had an upsetting dental experience? Yes No……. If yes, please describe: _____

_____

Have you ever been told you need to take premedication prior to dental treatment? _____

Please explain anything else about having dental treatment that you would like us to know? _____

_____

_____

How did you hear about our office? (Circle One)

Patient Referral Verizon Yellow Pages VA Gazette WMBRG Health Journal Direct Mailer

Saw Location while shopping KCSA Bulletin Online Search

Other_____

If referred by a patient, who referred you (this is to ensure they receive their referral credit?

_____

You will receive a $35 credit on your account for every patient you refer to our practice. Please be sure they mention your name at their first visit.

General supervision is defined as a written order issued by a dentist for specified treatments that are to be performed by a dental hygienist. These written orders entails that a Virginia state licensed dentist must examine a patient within the past seven months and issue a prescription for dental hygiene services. This prescription allows a dental hygienist to perform doctor prescribed hygiene procedures when the dentist is not present in the office.

I would like to be considered for general supervision: _____ (initial)

I would **NOT** like to be considered for general supervision: _____(initial)

CONSENT:

1. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**: By signing below I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.
2. I hereby authorize Dr. Michael C. Shuck or designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by Dr. Michael C. Shuck to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Michael C. Shuck to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.
3. **I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Michael C. Shuck or Quarterpath Dental Center. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the Dr. Shuck has a contractual agreement with my plan prohibiting all or a portion of such charges**.
4. By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above items**.

Patient/Guardian's Signature _____ **Date** _____