PATIENT REGISTRATION

Patient Name____Middle Initial________

If child, parent's name____

If married, name of spouse____

Street Address____

City______________State_____Zip__________Phone______________________

Patient employed by____

Business Address____

City______________State_____Zip__________Phone______________________

Present Position________________________________How long held______________

Spouse employed by____

Street Address____

City______________State_____Zip__________Phone______________________

Who will pay this account? ____

Social Security #____

Drivers License #____

In case of emergency, who should be notified? __________________________________

Phone number of person to be notified ____

Who may we thank for referring you? ____

Concerning your dental health, do you:

	Yes	No
Brush Daily	____	____
Floss Daily	____	____
Use fluoride rinse	____	____

Do you now have or have you ever had:

	Yes	No		Yes	No
Bleeding or sore gums	____	____	Clenching or grinding	____	____
Burning tongue or lips	____	____	Change in bite	____	____
Frequent blisters	____	____	Shifting of teeth	____	____
Swelling in mouth	____	____	Food impaction	____	____
Biting cheeks or lips	____	____	Periodontal therapy	____	____
Popping jaw	____	____	Loose teeth	____	____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Dr. Joan Knuth or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize payment of the dental benefits otherwise payable to me to be assigned directly to Dr. Joan K. Knuth D.D.S. I authorize Dr.Knuth to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE.**

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Patient/Guardian Signature   Date