DRS. RUBINSTEIN & DUCOFF

DENTAL REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

DATE_____

PATIENT NAME _____

_____

ADDRESS_____

CITY _____

STATE_____ZIP_____

E-MAIL_____

SEX F M AGE_____

BIRTHDATE_____

___MARRIED ____WIDOWED _____ SINGLE

___DIVORCED _____ PARTNERED

OCCUPATION_____

EMPLOYER_____

SPOUSE 'S NAME _____

BIRTHDATE_____

PHONE_____

DENTAL INSURANCE

INSURANCE COMPANY_____

SUBSCRIBER NUMBER_____

SUBSCRIBER 'S NAME_____

SECONDARY DENTAL INSURANCE

SUBSCRIBER' S NAME_____

INSURANCE COMPANY_____ _____

SUBSCRIBER NUMBER_____

PHONE NUMBERS

HOME_____

WORK_____ CELL PHONE_____

SPOUSE'S WORK NUMBER _____

SPOUSE'S CELL PHONE _____

IN CASE OF EMERGENCY CONTACT

NAME_____

RELATIONSHIP_____

HOME PHONE_____ CELL_____

DENTAL HISTORY

REASON FOR TODAY'S VISIT_____FORMER DENTIST_____

CITY _____ _____STATE_____ PHONE NUMBER_____DATE OF LAST DENTAL VISIT_____

HOW OFTEN DO YOU FLOSS_____ HOW OFTEN DO YOU BRUSH_____DO YOU SMOKE_____CLICKING OR POPPING JAW_____

SENSITIVITY TO HOT ____COLD_____ FOOD COLLECTING BETWEEN TEETH_____GRINDING TEETH_____ORTHODONTIC TREATMENT____

BAD BREATH_____BLEEDING GUMS_____SWOLLEN GUMS_____JAW PAIN_____LOOSE TEETH _____BROKEN FILLINGS_____

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIAL NOT PAID BY MY DENTALBENEFIT PLAN, UNLESS PROHIBITED BY LAW, OR THE TREATING DENTIST OR DENTAL PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN OF PROHIBITING ALL OR A PORTION OF SUCH CHARGES.TO THE EXTENT PERMITTED BY LAW. THE PRACTICE MAY DISCLOSE SUCH INFORMATION TO MY INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS PAYABLE FOR RELATED SERVICES

DRS. RUBINSTEIN & DUCOFF

____SIGN ____DATE