DALE FAMILY DENTISTRY
Caring for You...and Your Smile!

Registration

Kenneth G. Dale, DDS
4801 Paoli Pike, Suite 102
Floyds Knobs, IN 47119
812-923-8180 (Tel) • 812-923-1775 (Fax)
www.DaleFamilyDentistry.com
info@DaleFamilyDentistry.com

Patient Information

Name ______________ ____ ______________
First MI Last

How do you wish to be addressed? ______________

Today's Date:________ Birthdate:________ Age: ______

Social Security #:______________ Sex: ☐ M ☐ F

Residence: Street ______________

City ______________ State ______ Zip ______

Employer: ______________ Occupation: ______________

Check appropriate box:

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, School's Name ______________

School's City: ______________ Full time? ☐ Yes ☐ No

Whom may we thank for referring you? / How did you learn of our office?

____

Have you seen Dr. Dale before? ☐ Yes ☐ No

Previous Dentist: ______________

Telephone & Contact

Home Phone : ______________ Cell Phone: ______________

Work Phone : ______________ Dept./Ext.: ______________

E-mail address: ______________

Responsible Party Telephone Numbers (if different):

Home Phone : ______________ Work Phone : ______________

Where do you prefer to receive phone calls?

☐ Home ☐ Work ☐ Cell Phone ☐ Please do not call at Work

In the event of an Emergency, who should we contact?

Name : ______________ Relationship : ______________

Home Phone : ______________ Work Phone : ______________

Responsible Party

Responsible Party for Payment of this Account: ☐ Same as Patient

Name ______________ ____ ______________
First MI Last

Relationship to Patient: ______________

Birthdate: ______________ Social Security #: ______________

Residence: Street ______________

City ______________ State ______ Zip ______

Employer: ______________ Occupation: ______________

Is the Responsible Party a Patient in our Office? ☐ Yes ☐ No
☐ No, but will be

Dental Insurance

Do you have dental insurance? ☐ Yes ☐ No

If Yes, please continue...

Name of Insured (Policy Holder): ______________

Relationship to Patient: ______________

Insured's Birthdate: ______________

Insured's Social Security #: ______________

Employer: ______________

Employer's Address: ______________

Insurance Company: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: ______________

Group #: ______________ Employee ID #: ______________

Do you have any additional Insurance? ☐ Yes ☐ No If Yes, continue...

2nd Policy Holder Name: ______________

2nd Policy Holder Birthdate: ______________ Social Security #: ______________

2nd Policy Holder Employer: ______________

2nd Insurance Co. Name: ______________

Authorization & Payment

◆ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. ◆ 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 other health practitioners. ◆ I authorize and request my insurance company to pay directly to the dentist Insurance benefits otherwise payable to me. ◆ I understand that my dental insurance carrier may pay less than the actual bill for services. ◆ I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. ◆ I agree to pay collection costs and reasonable attorney fees in attempting to collect on this account or any future outstanding account balances. ◆ Interest charges (1½%/mo.,18% APR) may be applied to my past due account and there is a $15 fee for a returned check which I agree to pay. ◆ We do expect payment in full (less any estimated insurance) at each appointment, unless alternative financial arrangements are made. ◆ For your convenience, you may make a financial arrangement for your portion due by selecting one of our established financial options. Please ask for details of our extended payment plans. ◆ A $40 missed appointment fee may apply; see our appointment policy for full details.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

X ______________________________ ______________
Signature of Patient or Parent if Minor Date

DALE FAMILY DENTISTRY

Caring for You...and Your Smile!

History

Kenneth G. Dale, DDS
4801 Paoli Pike, Suite 102
Floyds Knobs, IN 47119
812-923-8180 (Tel) • 812-923-1775 (Fax)
www.DaleFamilyDentistry.com
info@DaleFamilyDentistry.com

Medical History

Physician's Name : ______________________ Office Phone : ______________ Date of Last Exam: ____________

	YES	NO	IF **YES**, PLEASE EXPLAIN BELOW:
◆ Are you under medical treatment now?	☐	☐	____________
◆ Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐	____________
◆ Are you taking any prescription medication(s)?	☐	☐	____________
◆ Are you taking any non-prescription medication or herbal supplements?	☐	☐	____________
◆ Do you smoke, chew, use snuff or any other forms of tobacco?	☐	☐	____________
◆ Do you use controlled substances?	☐	☐	____________

◆ Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metals ☐ Acrylic ☐ Latex ☐ Anesthetics ☐ Other ____________

◆ Do you have, or have you had, any of the following?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	AIDS or HIV Positive	☐	☐	Chemotherapy	☐	☐	Heart Attack	☐	☐	Mitral Valve Prolapse
☐	☐	Alcoholism	☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Disease	☐	☐	Nervousness
☐	☐	Allergies or Hives	☐	☐	Congenital Heart Disease	☐	☐	Heart Surgery	☐	☐	Pain in Jaw Joints
☐	☐	Anemia	☐	☐	Cosmetic Surgery	☐	☐	Heart Murmur	☐	☐	Psychiatric Care
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Heart Pacemaker	☐	☐	Radiation Treatment
☐	☐	Artificial Heart Valve	☐	☐	Drug Addiction	☐	☐	Hemophilia	☐	☐	Rheumatic Fever
☐	☐	Artificial Joints	☐	☐	Epilepsy or Seizures	☐	☐	Hepatitis A (infectious)	☐	☐	Sinus Trouble
☐	☐	Asthma	☐	☐	Emphysema	☐	☐	Hepatitis B (serum)	☐	☐	Stroke
☐	☐	Blood Transfusion	☐	☐	Frequent Headaches	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Bruise Easily	☐	☐	Glaucoma	☐	☐	Kidney Trouble	☐	☐	Tuberculosis (TB)
☐	☐	Cancer	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	Ulcers

◆ Have you ever had any serious illness not listed above? ☐ YES ☐ NO ____________

◆ Women Only: Are you ☐ Pregnant? / ☐ Think you might be? Due Date: ________ ☐ Nursing? ☐ Taking oral contraceptives?

COMMENTS: ____

____

Dental History

	YES	NO
◆ Do your gums bleed while brushing or flossing?	☐	☐
◆ Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
◆ Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
◆ Do you feel pain to any of your teeth?	☐	☐
◆ Do you have any sores or lumps in/near your mouth?	☐	☐
◆ Have you had any head, neck or jaw injuries?	☐	☐
◆ Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (Joint, Ear, Side of Face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	YES	NO
◆ Do you have frequent headaches?	☐	☐
◆ Do you clinch or grind your teeth?	☐	☐
◆ Have you ever had endodontic (root canal) treatment?	☐	☐
◆ Have you ever had any periodontal (gum) treatments?	☐	☐
◆ Have you had any orthodontic work (braces)?	☐	☐
◆ Do you have any teeth that you are interested in replacing?	☐	☐
◆ Have you ever had instruction on the correct method of brushing your teeth and the care of your gums?	☐	☐
◆ Are you interested in improving the appearance of you teeth? (e.g. changing the color, shape, spacing, or rotation)	☐	☐
◆ Are you apprehensive about dental treatment?	☐	☐

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

______________________________ ______________

Signature of Patient or Parent if Minor Date

Revised 09/2009