----------REGISTRATION----------

PATIENT CONTACT INFORMATION

Today's Date_____

Patient's Full Name_____Preferred name_____

Address_____ Home Phone ( ) _____

City, State, Zip_____ Cell Phone ( ) _____

Email Address_____ Work Phone ( ) _____

Other Seasonal Address/Phone if applicable _____

PERSONAL INFORMATION

Patient's SS#_____ Driver's License #_____State_____

Birthdate_____ Age_____ Sex ☐M ☐F Marital Status_____

ADDITIONAL INFORMATION

Employer_____Occupation_____

Business Address_____

Spouse Name_____Cell Phone_____

Spouse Birthdate_____SS#_____

In case of emergency, Please contact_____Phone #_____

DENTAL INSURANCE

Do you have dental insurance coverage? ☐Yes ☐No

Name of Company_____Name of Insured_____

Subscriber #_____SS# of Insured_____

Group #_____ Birthdate of Insured _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with (name of company)_____ and assign directly to Dr. Niles A. Syska, DDS and/or The Tooth Shop on 46, LLC. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative_____

Print name of Patient, Parent, Guardian or Personal Representative_____

Date_____Relationship to Patient_____

***WHO MAY WE THANK FOR REFERRING YOU TODAY*?_____**

DENTAL HISTORY

Reason for today's visit_____ Are you in pain? ☐Yes ☐No

Date of Last Dental Exam_____Date of Last Dental Xrays_____

Date of Last Cleaning_____How often do you brush_____How often do you floss_____

Place a mark on "YES" or "NO" to indicate if you have had any of the following

Bad breath	☐Yes ☐No		
Bleeding Gums	☐Yes ☐No	Lips or cheek biting	☐Yes ☐No
Blisters on lips or mouth	☐Yes ☐No	Loose teeth or broken fillings	☐Yes ☐No
Burning sensation on tongue	☐Yes ☐No	Mouth breathing	☐Yes ☐No
Chew on one side of mouth	☐Yes ☐No	Mouth pain, brushing	☐Yes ☐No
Cigarette, pipe or cigar smoking	☐Yes ☐No	Orthodontic treatment	☐Yes ☐No
Clicking or popping jaw	☐Yes ☐No	Pain around ear	☐Yes ☐No
Dry mouth	☐Yes ☐No	Periodontal treatment	☐Yes ☐No
Fingernail biting	☐Yes ☐No	Sensitivity to cold	☐Yes ☐No
Food collection between teeth	☐Yes ☐No	Sensitivity to heat	☐Yes ☐No
Bite/chew foreign objects	☐Yes ☐No	Sensitivity to sweets	☐Yes ☐No
Grinding teeth	☐Yes ☐No	Sensitivity when biting	☐Yes ☐No
Gums swollen or tender	☐Yes ☐No	Sores or growths in mouth	☐Yes ☐No
Jaw pain or tiredness	☐Yes ☐No		

I have general authority to perform all acts on my own behalf and I am responsible for my own decisions.
No other person or persons holds a Power of Attorney on my behalf.

PATIENT'S SIGNATURE_____**DATE**_____