



**Patient Information Registration & Update**

Date: \_\_\_\_\_ (For returning patients: if there are no changes you may note "no change" for each item that applies)

**SECTION 1: GENERAL INFORMATION**

Name: \_\_\_\_\_ Social Sec. # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Mobile: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email Address: \_\_\_\_\_

Sex:  M  F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married  Widowed  Separated/Divorced

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**SECTION 2: PARENT OR GUARDIAN OF PATIENT (IF PATIENT IS UNDER 18 YEARS OF AGE)**

Name: \_\_\_\_\_ Social Sec. # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Mobile: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

**SECTION 3: INSURANCE INFORMATION**

Subscriber's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Sec./Subscriber #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_



**SECTION 4: SECONDARY INSURANCE INFORMATION (IF APPLICABLE)**

Subscriber's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Sec./Subscriber #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

**SECTION 5: PERSON RESPONSIBLE FOR ACCOUNT**

Name: \_\_\_\_\_ Social Sec. # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Mobile: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email Address: \_\_\_\_\_

Sex:  M  F Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to patient: \_\_\_\_\_

**SECTION 6: GETTING TO KNOW YOU**

1. Why did you select our office? \_\_\_\_\_

2. Whom may we thank for referring you to our office? (Check all that apply)

Website  Online Advertisement  Search Engine (Google, Bing, Yahoo)

Yellow Pages  Print Advertisement: \_\_\_\_\_

Friend/Family Member: \_\_\_\_\_

My Physician: \_\_\_\_\_

3. Is another member of your family or relative a patient in our practice? \_\_\_\_\_

4. Person to contact in CASE OF EMERGENCY: \_\_\_\_\_

Home: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Mobile: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship: \_\_\_\_\_

5. Have your gums begun to bleed or feel tender?  Yes  No

6. Are you unhappy with the appearance or the color of your teeth?  Yes  No

# Dental Health Wellness Center

7. Are you experiencing any discomfort in your mouth?  Yes  No

If so, please explain: \_\_\_\_\_

8. Is there anything special you would like the Dr. Rouff to know about your visit today?  Yes  No

If so, please explain: \_\_\_\_\_

Please read and sign all 3 boxes below.

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the office at my next appointment without fail. I hereby authorize the dental office to administer medications and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. Notice of privacy practices: I have read the posted Notice of Privacy Practices Act of 1996 and regulations. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals and may be used and disclosed to treatment, payment, or healthcare operations.

1. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing below, I hereby authorize this office to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to this dental office. This "Signature on File" will be valid from this date and shall expire in one year or unless I cancel the authorization through written notice to this office.

2. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize this office to take photographs, slides, and/or videos of my face, jaws and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lecture, demonstrations, advertising (including website publication, newspapers, magazines, phone, books television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

3. Signature: \_\_\_\_\_ Date: \_\_\_\_\_