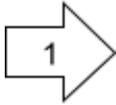
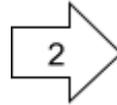


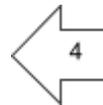
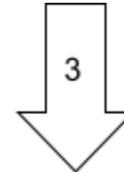
David J. Shock, DDS
Patient Registration



<i>Personal Information</i>		
Name:		
Parent's Name (if child):		
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Birthdate:		
Social Security Number:		
Email address:		
Place of Employment		
Work Phone:		



<i>Dental Insurance</i>
Insurance Company:
Group #
Insured's information (if different than at left)
Name:
SSN:
Birthdate:
Employer:



<i>Dental History</i>	
Do you have a specific dental problem? If so, what?	Yes No
Do you feel nervous about having dental treatment?	Yes No
Are your teeth sensitive to hot, cold, sweets, pressure? (please circle which)	Yes No
Is there anything you would like to change about your smile?	
Please rank the following in the order in which they would keep you from receiving dental care:	
Fear of pain _____	Lack of concern _____
Cost of treatment _____	Missing work time _____

<i>Important Contacts</i>		
In Case of Emergency contact:		
Relation:		
Home Phone:		
Work Phone:		
Address:		
City:	State:	Zip:
Who Referred You to Our Office?		

Consent for Treatment

The undersigned hereby authorizes Dr. Shock to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Shock to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Shock to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Dr. Shock choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I also assign all insurance benefits to Dr. Shock. Any payments received by Dr. Shock from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

Patient Signature (Parent of Child): _____ Date _____ Witness: _____