David J. Shock, DDS
Patient Registration

1

Personal Information

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:

2

Dental Insurance

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

3

Important Contacts

In Case of Emergency contact:
Relation:
Home Phone:
Work Phone:
Address:
City: State: Zip:
Who Referred You to Our Office?

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Dental History

Do you have a specific dental problem? Yes No
If so, what?

Do you feel nervous about having dental treatment? Yes No
Are your teeth sensitive to hot, cold, sweets, pressure? Yes No
(please circle which)
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 _____

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: _____