Welcome to Redick Family Dentistry!

We are glad you are going to be a part of our practice. We value attention to detail and want to be correct and complete, so please fill out the following information. Thank you!

NEW PATIENT REGISTRATION

Patient's Last Name:______________________First:___________________ Middle Initial:___
Date of Birth ____/____/_______Email__________________________________
Street address____________________________City________________State ___Zip________
Employer________________________________Work #__________________
Home #_______________________Cell #_________________________
How did you hear about out office? Internet Friend Phonebook Insurance carrier
Who may we thank for referring you?____

INSURANCE INFORMATION

Primary Insurance
Policyholder______________________Policyholder SSN________________
Date of Birth / / Group #_____________Member ID#________________________
Policyholder's Employer__________________________
Patient's relationship to policyholder Self Spouse Child

Secondary Insurance
Policyholder______________________Policyholder SSN______________________________
Date of Birth / / Group #_____________ Member ID #________________________
Policyholder's Employer______________________
Patient's relationship to policyholder Self Spouse Child

EMERGENCY CONTACT

NAME_________________________Relationship to patient____________Ph #____________

PATIENT DENTAL HISTORY

Are you in dental discomfort/pain today? Y N
Are your teeth sensitive to hot or pressure? Y N
Do you have frequent headaches? Y N
Are any of your teeth loose? Y N
Have you had orthodontic treatment? Y N
Have you ever been treated for gum disease? Y N
Are your teeth sensitive to cold or sweet? Y N
Do you clench or grind your teeth? Y N
Are you missing any teeth? Y N
Do your gums bleed when you floss/brush? Y N
Are you concerned with having bad breath? Y N
Approximate date of your last dental visit?__________
How do you feel about the appearance of your teeth?
____
Is there anything you would like to express about your dental health or past dental treatment?
____

Minor/Child CONSENT

I, BEING THE PARENT OR GUARDIAN OF THE PATIENT LISTED ABOVE, DO HEREBY REQUEST AND AUTHORIZE THE DENTAL STAFF TO PERFORM RECOMMENDED SERVICES FOR MY CHILD, INCLUDING BUT NOT LIMITED TO X-RAYS, THE ADMINISTRATION OF FLUORIDE, LOCAL ANESTHETICS AS DEEMED ADVISABLE BY THE DOCTOR(S), WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED.____________________________ GUARDIAN SIGNATURE
___________ DATE