Glyndon Family Dentistry _DR. JAY C. TOTH_ **_REGISTRATION HISTORY_**

Please complete carefully and in entirety. If you need assistance please ask for help.

Patient's Name____Nick Name ____________Date_____/_____/______

Spouse's Name_______________________________________ Guardian's Name ________________________________

Patient's Date Of Birth ____________ Age_____ Weight_______ M / F Patient's Occupation______________________

Patient's address____
Street Apt. #

____
City State Zip

Patient's Home # (____)______________Work #(____)_________________ Cell Phone # (____)____________________

E-Mail Address: ______________________________________ _Only to be used for internal communication with the patient._

Whom may we thank for referring you?

ACCOUNTING

Person responsible for this account (Guarantor)____________________________________Home Ph.#(____)___________

Billing Address:____

Guarantor employed by_____________________________Position______________________ Bus. Ph.#(____)__________

Bus. Address
(Street,City,State,Zip)____

Guarantor's Social Security No._________________________________Driver's License No.________________________
Additional family members on the same account:

1. **2.** **3.** **4.**

DENTAL INSURANCE

Dental Insurance Plan (if any)____Group No.___________________

Policyholder's: Name _________________________ Date of birth____/____/___ Social Security No.__________________

Mailing address of Ins. Co.____

SECONDARY Dental Insurance Name:____Group No.___________________

Policyholder's: Name_________________________ Date of birth___/____/___ Social Security No.__________________

Mailing address of Secondary Ins. Co: ____

DENTAL HISTORY

Pupose of this appointment?____
Are you interested in _emergency_ treatment or _routine care_?____
Date of last dental appointment: _____________________For what____
Previous dentist: __________________________________ City and State:_______________________________________

	YES	NO
Has patient experienced any undesirable reaction from any previous dental care?.	_____	_____
Are you dissatisfied with the appearance of your teeth?.	_____	_____
Are you dissatisfied with the function of your teeth?.	_____	_____
Has fear or discomfort kept you from your regular dental care?	_____	_____
Are you dissatisfied with your past dental care?.	_____	_____
Is there history of trauma or injury to your mouth?.	_____	_____
Are you concerned about any special dental problems?.	_____	_____

Describe:____

CHILDREN:

Is this your child's first visit to a dentist? YES / NO Does your home have _well_ or _city_ water?____________________
Has your child been premedicated or received "Twilight Sleep" for dental treatment? YES / NO

OVER PLEASE