



1507 West Yosemite Avenue • Manteca, CA 95337

(209) 823-9341 • valleyoakdentalgroup.com

Welcome

Adult Patient Registration Form

Patient's Name: _____ Date: _____
Last First Middle Initial

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

If you work, may we call you at your work number to confirm your appointment? (Check one): Yes No

Mailing Address (if different than above): _____

Names and ages of family members (sons, daughters, spouse):

Name	Age	Boy	Girl	Spouse
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A. Your Employment Information:

Name of Employer: _____

Employer Address: _____

Present Position: _____ How long: (years) _____ (months) _____

Dental Insurance Name: _____ Group #: _____ Local #: _____

Insurance Address: _____

Social Security Number: _____ Date of Birth: _____ Driver's Lic.#: _____

B. Spouse's Name: _____ Husband Wife

Social Security Number: _____ Date of Birth: _____ Driver's Lic.#: _____

Name of Employer: _____

Employer Address: _____

Present Position: _____ How long: (years) _____ (months) _____

Dental Insurance Name: _____ Group #: _____ Local #: _____

Insurance Address: _____

C. MARITAL STATUS: Single Married Widowed Other _____

If there is any change in your marital status, please let us know

D. Are there other family members established patients in our practice?

If so, under what name is the account: _____

E. Dental Information

1. How long has it been since your last dental visit?

Less than 6 months 6 months 1 year 2 years Over 2 years

2. Why did you leave your last dentist?

I moved Did not have my interests in mind I had financial problems within the office
 The dentist moved Did not explain things Unresolved problems with office
 I always had to wait Was not gentle Prefer not to say
 Inconvenient hours Office staff was uncaring

3. Why did you choose to come in at this time?

General Checkup I have areas of pain
 I have broken fillings or teeth I've put it off too long Other _____

4. How would you describe the general condition of your teeth?

Excellent Good Fair Poor

5. If you could change the appearance of your teeth, what would you change?

Color Crowding or crooked teeth Black discolored filling Other _____

6. Do you believe that having your teeth cleaned regularly will help prevent gum disease, and thereby prevent you from losing your teeth? Yes No

7. Do you smoke a pack or more of cigarettes a day? Yes No

8. Do you believe dental disease is avoidable? Yes No

9. Are you apprehensive about your visit here? Yes No

Whom may we thank for referring you to VALLEY OAK DENTAL GROUP? We want to thank them because we are always accepting new patients and we welcome all referrals. Name: _____

THIS IS MY AUTHORIZATION TO DR. _____ TO PERFORM ALL NECESSARY DIAGNOSTIC, PREVENTIVE, RESTORATIVE, SURGICAL, ORTHODONTIC AND ASSOCIATED DENTAL TREATMENT. I WILL BE ADVISED OF ALL METHODS, MEDICATIONS AND AGENTS AS MAY BE INDICATED AND CONSENT THEREBY, MY CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED IN WRITING.

DATE: _____ SIGNATURE: _____

AUTHORIZATION TO PAY BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED, VALLEY OAK DENTAL GROUP, FOR DENTAL BENEFITS. OTHERWISE MADE PAYABLE TO ME FOR DENTAL SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE: _____ SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT: _____