

-----REGISTRATION-----

**PATIENT CONTACT INFORMATION**

Today's Date \_\_\_\_\_

Patient's Full Name \_\_\_\_\_ Preferred name \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Cell Phone (    ) \_\_\_\_\_  
Email Address \_\_\_\_\_ Work Phone (    ) \_\_\_\_\_  
Other Seasonal Address/Phone if applicable \_\_\_\_\_

**PERSONAL INFORMATION**

Patient's SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Marital Status \_\_\_\_\_

**ADDITIONAL INFORMATION**

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_  
Spouse Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Spouse Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
In case of emergency, Please contact \_\_\_\_\_ Phone # \_\_\_\_\_

**DENTAL INSURANCE** Do you have dental insurance coverage? Yes No

Name of Company \_\_\_\_\_ Name of Insured \_\_\_\_\_  
Subscriber # \_\_\_\_\_ SS# of Insured \_\_\_\_\_  
Group # \_\_\_\_\_ Birthdate of Insured \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with (name of company) \_\_\_\_\_ and assign directly to Dr. Niles A. Syska, DDS and/or The Tooth Shop of Ocala, LLC. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_  
Print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**WHO MAY WE THANK FOR REFERRING YOU TODAY?** \_\_\_\_\_

**DENTAL HISTORY**

Reason for today's visit \_\_\_\_\_ Are you in pain? Yes No  
Date of Last Dental Exam \_\_\_\_\_ Date of Last Dental Xrays \_\_\_\_\_  
Date of Last Cleaning \_\_\_\_\_ How often do you brush \_\_\_\_\_ How often do you floss \_\_\_\_\_

Place a mark on "YES" or "NO" to indicate if you have had any of the following

- |                                  |  |                                |  |
|----------------------------------|--|--------------------------------|--|
| Bad breath                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lips or cheek biting           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Gums                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning sensation on tongue      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chew on one side of mouth        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette, pipe or cigar smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry mouth                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fingernail biting                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food collection between teeth    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bite/chew foreign objects        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grinding teeth                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in mouth      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gums swollen or tender           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                |  |
| Joint pain or tiredness          | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                |  |

**I have general authority to perform all acts on my own behalf and I am responsible for my own decisions.  
No other person or persons holds a Power of Attorney on my behalf.**

**Patient (print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_