

DR. LARRY SCHOONOVER

P.O. Box 672 1 French Street

Clendenin, WV 25045

(304) 548-7227

REGISTRATION AND CONSENT FORM

A. General Information

Name: _____ Social Security No.: _____
 First Middle Last

Nickname/Preferred Name: _____

Birthdate: _____ Sex: _____ Marital Status: _____

Address: _____
 Street or Box City State Zip

Telephone: Home: _____ Work: _____

Occupation: _____ Employer/School: _____

Referred by: _____ Yellow Pages _____ Advertisement _____

E-Mail: _____

B. Responsible Party for Payment

Name: _____ Social Security No.: _____
 First Middle Last

Employer: _____

Work Address: _____ Work Phone _____
 Street or Box

 City State Zip

Primary Insurance Company

Name: _____

Insured's Name: _____

Employer Providing Ins.: _____

Policy/Certificate No.: _____

Secondary Insurance Company

Name: _____

Insured's Name: _____

Employer Providing Ins.: _____

Policy/Certificate No.: _____

C. Person to be contacted in case of emergency

Name: _____ Relationship to Patient: _____

Address: _____ Telephone: _____

D. Consent

I, the undersigned, voluntarily consent to the receipt of routine dental care from Dr. Schoonover, a general dentist, and his authorized staff. This may include X-rays, study models, photographs, or other diagnostic aids to make a thorough diagnosis of dental needs, in addition to any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic (numbing) agents incurs a certain risk. Certain risks of anesthesia and/or dental treatment may include, but are not limited to, pain, swelling, bleeding or bruising, damage to adjacent teeth, fillings or crowns; temporary or permanent lip or tongue numbness, sinus entry and/or problems, soreness at injection site, allergic reaction to any drugs or medication and/or infection.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination by Dr. Schoonover and his staff.

I hereby authorize my insurance benefits be paid directly to Dr. Schoonover. I also authorize the release of any information required by third parties to obtain payment for services rendered. I am financially responsible for all services rendered. I further understand that a one and one-half percent finance charge (18 percent annually) will be added to any balance over 60 days.

Patient Signature _____ Date _____

Parent or Responsible Party _____

Relationship to Patient _____

Witness _____

PRESENT DENTAL CONDITION

I brush (how often) _____

I floss (how often) _____

Please check all that apply to you:

- _____ I am in pain.
- _____ I am swollen.
- _____ I have decay.
- _____ I clench or grind my teeth.
- _____ I have a broken filling.
- _____ I have gum problems.

- _____ I am proud of my smile.
if not, why?
- _____ Crooked teeth.
- _____ Missing teeth.
- _____ Dark teeth.
- _____ Bad teeth.
- _____ Dark fillings.

Other: _____

FUTURE PLANS

Please check items that apply to you:

- _____ I am interested in a preventive dental care program with regular exams and cleaning every 6 months.
- _____ I want to keep my teeth as long as I can.
- _____ I want extractions and dentures.
- _____ I want some missing teeth replaced.
- _____ I want straighter teeth.
- _____ I want whiter teeth.
- _____ I want only relief of pain.
- _____ I want _____

