



ANDRÉ GRENIER, D.M.D., P.L.L.C.

Diplomate of the American Board of Periodontology • Practice Limited to Periodontics, Laser and Implant Surgery

PATIENT REGISTRATION

First Name _____ Last Name _____ Middle Initial _____

Street Address _____ Apt/Unit# _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Ext _____

Date of Birth _____ SSN# _____ Drivers Lic. _____

E-mail _____ Sex Female Male

Single Married Widowed Divorced Separated

INSURANCE INFORMATION

Name of Insured _____ Policy # _____

Ins. Company _____ Group# _____

Address _____ EMPLOYER _____

Insured SSN _____ Insured DOB _____

Secondary Insurance _____ Name of Insured _____

Policy # _____ Insured SSN _____ Address _____

DENTAL HISTORY

Name of Dentist _____ How long have you been their patient _____

What is your main concern today? _____

When was your last dental cleaning? _____ Full mouth Xrays? _____

Please circle all those that apply to your current dental health:

Bleeding gums Gum recession Bad breath Loose teeth Removable partials or dentures

Dental Implants Pain or sensitivity when chewing TMJ pain Occlusal guard

Payment is required prior to the beginning of your treatment. Insurance coverage is only an estimation. Guarantor is responsible for all treatment not covered by insurance. All invoices not paid within 90 days of the date of service shall bear interest at the highest rate permitted by law. In the event it becomes necessary to retain the service of an attorney or collection agency to collect any sum due Dr. Grenier, patient shall be responsible for all fees and costs incurred in connection therewith, whether or not litigation is commenced.

Signature of Patient or Guardian _____ Date _____