PATIENT REGISTRATION FORM

Email: Today's Date:

Preferred Name: O Miss O Mr. O Mrs. O Ms. O Dr. Referred by:

Name: Last First Middle Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: O Full Time O Part Time Please provide school info: School Name:_____

Employment Status: O Full Time O Part Time O Retired Address:_____

Marital Status: O Married O Single O Divorced O Separated O Widowed Address 2:_____

Pref. Pharmacy: Phone: ( ) City, State, Zip:_____

DENTAL INSURANCE INFORMATION

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: O Self O Spouse O Child O Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer:_____ Ins. Company: _____

Address:_____ Address: _____ Address

2:_____ Address 2: _____ City,

State, Zip:_____ City, State, Zip: _____

ID#: _____ GROUP#:_____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: O Self O Spouse O Child O Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer:_____ Ins. Company: _____

Address:_____ Address: _____ Address

2:_____ Address 2: _____ City,

State, Zip:_____ City, State, Zip: _____

ID#: _____ GROUP#:_____

DENTAL INFORAMTION For the following questions, mark (X) your responses to the following questions.

	Yes	No
Do your gums bleed when you brush or floss?	O	O
Are your teeth sensitive to cold, hot, sweets or pressure?	O	O
Is your mouth dry?	O	O
Have you had any periodontal (gum) treatments?	O	O
Have you ever had orthodontic (braces) treatments?	O	O
Are you currently experiencing dental pain or discomfort?	O	O
Do you have any clicking, popping or discomfort in the jaw?	O	O
Do you brux or grind your teeth?	O	O
Do you have sores or ulcers in your mouth?	O	O
Do you wear dentures or partials?	O	O

Primary Medical Physician's Name:_____

Date of last regular checkup:_____

Last time you saw a Dentist for a regular checkup: _____

Last cleaning: _____

Last dental x-rays: _____

What is the reason for your dental visit today?

How do you feel about your smile?

Anything that would prevent you from getting your needed dental work? Y N Explain/Circle as to why:

MONEY TIME FEAR OTHER

RECEIVE A $25 CREDIT FOR EVERY PATIENT THAT YOU REFER!!!! JUST MAKE SURE THEY MENTION YOUR NAME WHEN SCHEDULING!!!!