PATIENT REGISTRATION FORM

Welcome to our Practice

Date:_____

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Title:_____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr./Ms./Mrs/etc

Date of Birth: _____ **SSN:** _____ **Previous Visit:** _____

Email Address: _____ **Best Time to Call:** _____

Phone: _____ _____ _____ _____
Home Mobile Work Ext.

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Please enter Employer and Occupation:

_____

How did you hear about us? _____ **Newsletter** ____ **Website** ____ **Facebook** ____**Google**

In an emergency who should be notified? Please enter Name and Phone number below:

_____

RESPONSIBLE PARTY INFORMATION

Please enter information for the person financially responsible for the account

◯ If the Patient is the responsible party, please check here, skip this section and continue to the next section.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ _____ _____
Last First MI Preferred Name

Title:_____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr./Ms./Mrs/etc

Date of Birth: _____ **SSN:** _____ **Previous Visit:** _____

Email Address: _____ **Best Time to Call:** _____

Phone: _____ _____ _____ _____
Home Mobile Work Ext.

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

DENTAL INSURANCE INFORMATION

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ **ID#:** _____ **Group#:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Primary Insurance: _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insurance Company Phone Number: _____

Secondary Insurance: _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insurance Company Phone Number: _____

Insurance Authorization:

By signing this form, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. If you have Secondary Dental Insurance, please present your insurance card to the front desk at the time of your appointment.

Patient Signature _____ *Date* _____

DENTAL HISTORY INFORMATION

How would you rate the condition of your mouth?: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number: _____

Date of most recent dental exam and dental x-rays: _____

I routinely see my dentist every: ◯ 3 mo. ◯ 4 mo. ◯ 6 mo. ◯ 12 mo. ◯ Not Routinely

What is the reason for your visit today? _____

_____

Existing conditions (check all that apply)

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Have dry mouth
- ☐ Food gets trapped between any teeth
- ☐ Having popping and/or clicking of your jaw joint
- ☐ Clench or grinding your teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Have or had gum recession
- ☐ Have or had a burning sensation in your mouth
- ☐ Would like to change the appearance of my smile
- ☐ Had trouble getting numb
- ☐ Had or have braces (orthodontic treatment)
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Have whitened or bleached your teeth
- ☐ Have difficulty chewing
- ☐ Wear or have worn a bite appliance
- ☐ Have been treated for gum disease
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____