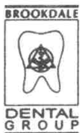

PATIENT REGISTRATION

ID: ________ Chart ID: ________

First Name: ________ Last Name: ________ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: ________

☐ Responsible Party

Referred by: ________

Responsible Party (if someone other than the patient)

First Name: ________ Last Name: ________ Middle Initial: ____

Address: ________ Address 2: ________

City, State, Zip: ________ Pager: ________

Home Phone: ________ Work Phone: ________ Ext: ____ Cellular: ________

Birth Date: ________ Soc Sec: ________ Drivers Lic: ________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ________ Address 2: ________

City: ________ State / Zip: ____ ________ Pager: ________

Home Phone: ________ Work Phone: ________ Ext: ____ Cellular: ________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ________ Age: ____ Soc. Sec: ________ Drivers Lic: ________

E-mail: ________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ________ Pref. Dentist: ________

Employer ID: ________ Pref. Pharmacy: ________

Carrier ID: ________ Pref. Hyg.: ________

Section 3

Additional Comments:

***In case of Emergency** ________

Phone ________

Primary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Secondary Insurance Information

Name of Insured: ________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ________ Insured Birth Date: ________

Employer: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Ins. Company: ________

Address: ________

Address 2: ________

City,State,Zip: ________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

(Please Turn Over)

Dental History

Previous Dentist____
Name *Address*

Phone_______________________ When was your last visit?_______________

Reason for visit______________________________Were x-rays taken at that visit? Yes/No

Are you happy with the appearance of your teeth?(if no, explain)________________________

____

Are you anxious about receiving dental treatment Yes/No

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING-PLEASE CHECK

- □ **Teeth sensitive to cold, heat, sweets or pressure**
- □ **Bleeding gums, How long?__________**
- □ **Food impaction**
- □ **Clenching or grinding**
- □ **Burning of tongue**
- □ **Swelling or lumps in mouth**
- □ **Frequent blisters on lips or mouth**
- □ **Pain around ear**
- □ **Unusual sounds in ear while eating**
- □ **Frequency of brushing______**
- □ **Inter dental stimulators**
- □ **Disclosing tablets or solution**
- □ **Other_______________________**
- □ **Bad breath**
- □ **Unpleasant taste**
- □ **Unfavorable dental experience**
- □ **Complaints from extractions**
- □ **Periodontal treatment**
- □ **Orthodontic treatment**
- □ **Mouth breathing**
- □ **Oral habits, i.e, fingernail biting**
- □ **Texture of toothbrush_________**
- □ **Dental Floss**
- □ **Water jet device**
- □ **Fluoride supplements**

(Please Turn Over)