

Registration and Dental History

Patient's Name (First): _____		(Last): _____		(Middle Initial): _____	
Preferred Name: _____		Date of Birth: _____		Age: _____ Sex: MALE FEMALE	
Address : _____			City, State, Zip: _____		
Cell Phone#: _____		Work #: _____		Other #: _____	
E-Mail: _____		Best Contact: EMAIL TEXT CELL HOME			
Social Security#: _____			Driver's License #: _____		
Marital Status: SINGLE MARRIED WIDOWED SEPARATED DIVORCED					
Spouse's Name or (If a minor) Parent's Name: _____					
Spouse's Work Phone: _____			Cell #: _____		
RESPONSIBLE PARTY INFORMATION					
Responsible Party Name (if different from patient): _____				Relationship: _____	
Responsible Party Address, City, State, Zip: _____					
Home Phone#: _____		Work #: _____		Cell #: _____	
Employer: _____			Employer Address: _____		
INSURANCE & EMPLOYER INFORMATION					
Insurance Carrier Name: _____					
Subscriber's Name: _____			Subscriber's Date of Birth: _____		
Relation to Patient: SELF SPOUSE CHILD OTHER			Subscriber's Phone #: _____		
Subscriber's SS#: _____		Insurance ID #: _____		Group #: _____	
Insurance Carrier Address, City, State, Zip: _____					
Medicaid #: _____					
Employment Status: FULL TIME PART TIME UNEMPLOYED			Student Status: FULL TIME PART TIME		
Employer: _____				Phone #: _____	
Employer Address, City, State, Zip: _____					
DENTAL INFORMATION					
Do your gums bleed when you brush?			YES NO Don't Know		
Have you ever had orthodontic (braces) treatment?			YES NO Don't Know		
Are your teeth sensitive to cold, hot, sweets or pressure?			YES NO Don't Know		
Do you have earaches or neck pains?			YES NO Don't Know		
Have you had any periodontal (gum) treatments?			YES NO Don't Know		
Do you wear removable dental appliances?			YES NO Don't Know		
How do you feel about the appearance of your teeth? _____					
If you have a current dental problem, how would you describe it? _____					
What was the name of your previous dentist? _____				Office#: _____	
Date of your last dental exam: _____			Date of your last dental x-rays: _____		
What was done at that time? _____					
EMERGENCY CONTACT					
Emergency Contact:				Phone/Cell #: _____	
(Please list closest relative or friend whose address is different from yours)					
Relationship to Patient: _____					
Emergency Contact Address, City, State, Zip: _____					
Preferred Pharmacy: _____			Phone #: _____		
OTHER					
How did you hear about us?					
Have you or another member of your family been treated here? If so, who? _____					
Would you like to receive appointment reminders via text messages; YES NO via email? YES NO					