P A T I E N T R E G I S T R A T I O N

Please Complete The Following Confidential Information: Date _____

Name _____ Male ☐ Female ☐ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

e-mail Address _____ Cell Phone _____

Married ☐ Single ☐ Child ☐ Other _____ Birth date _____ Home Phone _____

Driver's License # _____ Patient or Parent's Employer _____

Business Address _____ Business Phone _____

Spouse or Parent's Name _____ Employer _____ Wk Phone _____

If Student, Name of School/College _____ City _____ State ____ Full Time ☐ Part Time ☐

Getting to Know You

Is a family member or friend a patient at our office? Yes ☐ No ☐ Name _____ Relation _____

Whom May We Thank for Referring You? _____ Ins. Directory ☐ Website ☐ Other _____

Emergency Contact _____ Relation _____ Phone _____ Other _____

Closest Relative Not Living With You _____ Relation _____ Phone _____

Address _____ City _____ State _____ Zip _____

Dental Insurance

Primary Insurance Company _____ Group No. _____ Employee _____

Employee Date of Birth _____ Employee SS# _____ Employee Work Phone _____

Union or Local No. _____ Employer _____ City _____

Secondary Insurance Company _____ Group No. _____ Employee _____

Employee Date of Birth _____ Employee SS# _____ Employee Work Phone _____

Union or Local No. _____ Employer _____ City _____

Person Financially Responsible for Account

Name _____ Soc. Sec. # _____ Phone _____

Address _____ City _____ State _____ Zip _____

Relation _____ Occupation _____ Employer _____ Work Phone _____

Patient Dental History/Preferences

Reason for Visit _____ Any Discomfort _____

Any bleeding when you brush/floss Yes ☐ No ☐ Have you ever been told you have a gum disease? Yes ☐ No ☐

When was your last dental visit? _____ How often do you visit dentist per year? _____

Please rate from 1 to 10 (10 being the worst) the level of fear or anxiety you have about your dental visits _____

Do you experience any bad breath? Yes ☐ No ☐ If yes, please rate from 1 to 10 (10 being the worst) _____

Yes☐ No☐	My teeth are stained, discolored, has spots	Yes☐ No☐	I would like to have a nicer smile
Yes☐ No☐	My teeth are chipped or worn w/ rough edges	Yes☐ No☐	I have dark and unsightly fillings
Yes☐ No☐	My teeth seem out of proportion	Yes☐ No☐	I don't like the spaces between my teeth
Yes☐ No☐	My teeth are crowded and crooked	Yes☐ No☐	I have old unsightly crowns with black lines
Yes☐ No☐	My gums are swollen, receding &/or bleeding	Yes☐ No☐	I cover my mouth when I smile

We will be happy to answer any question & show you how easy it is to create a beautiful new smile you may like to have.