Patient Registration Form

Date:_____ SSN:_____ Date of Birth:_____ Sex: Male ☐ Female ☐

Patient Name: _____
First Name Last Name Middle Initial

Address:_____ City:_____ State: _____ Zip: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated E-Mail:_____

☐ Minor ☐ Widowed ☐ Partnered for ____years

Patient Employer/School: _____ Occupation: _____

Insurance Information

Responsible Party: _____ Relationship to Patient:_____

Insurance Co.: _____ Policy Holder's Name: _____

Date of Birth: _____ SSN:_____ Employer: _____

Insurance ID#: _____ Group Number: _____

Secondary Insurance?

Responsible Party: _____ Relationship to Patient:_____

Insurance Co.: _____ Policy Holder's Name: _____

Date of Birth: _____ SSN:_____ Employer: _____

Insurance ID#: _____ Group Number: _____

Dental History:

Reason for Today's Visit: _____ Former Dentist: _____

City/State: _____ Date of Last Dental Visit: _____ Date of Last X-Rays: _____

Check "yes" or "no" to indicate the following:

Yes ☐ No ☐ Bad breath
Yes ☐ No ☐ Bleeding Gums
Yes ☐ No ☐ Burning sensation on tongue
Yes ☐ No ☐ Cigarette, pipe or cigar smoking
Yes ☐ No ☐ Clicking or popping jaw
Yes ☐ No ☐ Dry mouth
Yes ☐ No ☐ Food collection between teeth
Yes ☐ No ☐ Grinding teeth
Yes ☐ No ☐ Swollen or tender gums
Yes ☐ No ☐ Jaw pain or tiredness
Yes ☐ No ☐ Loose teeth or broken fillings

Yes ☐ No ☐ Mouth Breathing
Yes ☐ No ☐ Orthodontic treatment
Yes ☐ No ☐ Periodontal treatment
Yes ☐ No ☐ Sensitivity to heat or cold
Yes ☐ No ☐ Sensitivity to sweets
Yes ☐ No ☐ Sensitivity when biting
Yes ☐ No ☐ Sores or growths in your mouth
How often do you floss? _____
How often do you brush?_____
Do you like your smile?_____

Whom May We Thank for Referring You?_____