DENTAL REGISTRATION

ABOUT YOU

Patient Name: ____ SS# ______-______-______
Street Address: ____________________________ City ____________________State _____ Zip ___________
Home Phone: ____________________ Work Phone: ____________________ Cellphone: ________________
Sex: M ❑ F ❑ Date of Birth____/_____/______ ❑ Single ❑ Married ❑ Separated ❑ Divorced
Employer Name: ____________________________ Address: ____________________________________
Occupation: ________________________________ email: ______________________________________
Spouse's Name: _____________________________ Spouse's Employer: ____________________________
Who may we thank for referring you? ____

FOR OUR INSURED PATIENTS

Primary Subscriber Name: ______________________________ SS# ____-____-_____ Date of Birth ____/____/____
Address: ________________________________ City ____________________ State ______ Zip __________
Employer: _______________________________ Address: ____
Insurance Company ___________________________Group #: ______________________________________
Is there secondary insurance? If so complete the following:
Subscriber's name ____________________________________SS# _________________________________
Date of Birth: ____________________ Insurance Company: _______________________________________
Group #: ________________________________
I authorize release of any information regarding my treatment to my insurance company.

____________________________________ ______________________________

Patient or Subscriber (if present) Date

EMERGENCY CONTACT INFORMATION

Name: ____________________________________ Relationship ______________________________
Home Phone: _______________________ Work Phone: _____________________________

Reason for today's visit: ____

Previous Dentist/Date of last visit ____
Place a mark on "yes" or "no" to indicate if you currently have had any of the following:

Burning/Numbness sensation on tongue, lip, cheek	❑ Y	❑ N	Loose teeth or broken fillings	❑ Y	❑ N	Chew on one side of mouth	❑ Y	❑ N
Clicking or popping jaw	❑ Y	❑ N	Mouth pain, brushing	❑ Y	❑ N	Grinding teeth	❑ Y	❑ N
Sensitivity to cold	❑ Y	❑ N	Pain around ear	❑ Y	❑ N	Sensitivity to sweets	❑ Y	❑ N
Sensitivity when biting	❑ Y	❑ N	Sensitivity to hot	❑ Y	❑ N	Jaw Pain or tiredness	❑ Y	❑ N
			Swollen/Tender gums	❑ Y	❑ N			