PATIENT REGISTRATION

Today's Date:

Patient Information:

First Name: Last Name: Middle Initial:

Preferred Name:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

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

Birth date: Social Security #: Drivers Lic#:

E-mail: □ I would like to receive email

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Referred By:

Responsible Party: (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #: Drivers Lic#:

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Primary Insurance Information:

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

Employer ID#: Group#:

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Phone #

Secondary Insurance Information:

Name of Insured:

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer ID:

Carrier ID:

Insured Social Security #:

Insured Birth date:

Employer:

Address:

Address 2:

City, State, Zip:

Insurance Company:

Address:

Address 2:

City, State, Zip:

Phone #:

Please Initial:

_____I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Emergency Information:

Whom should we contact?____

Relation:____

Home Phone#_________________________________

Work Phone #_________________________________

Cell Phone#___________________________________

Who is your Medical Doctor?____

Medical Doctor's Phone #:____

Dental Information:

Reason for Today's Visit: Exam Emergency Consultation

Are you in Pain? No Yes How Long?_________________________________

Please indicate by circling any of the following problems:

Discomfort, clicking, or popping in jaw	Lost/Broken Filling(s)	Stained Teeth
Red Swollen or Bleeding gums	Teeth grinding	Locking Jaw
Sensitive tooth, teeth or gums	Ringing in Ears	Bad breath
Blister/ Sores in or around the mouth	Broken/Chipped tooth	

Other____

Do you require pre-medication? Yes No Don't Know

Do you have any concerns about your teeth you want us to be aware of? ___________________________

Would you like whiter teeth?____

Previous Dentist___________________________________ Phone #_______________________________

Last Dental Exam____/____/___ Last Dental X-rays____/____/____

Times a day you brush? _____________________________ Times a week you floss? _______________

What type of tooth brush bristles do you use? Soft Medium Hard

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

_________I acknowledge and have received a copy of the Summary of Privacy Notice

Signature____Date:_____________________