ID: Chart ID:

PATIENT REGISTRATION

Who may we thank for referring you to our office? _____

Patient Information

First Name _____ Last Name _____ Middle Initial _____
Address _____ Address 2 _____
City, State, Zip _____ Pager _____
Home Phone _____ Work Phone _____ Ext _____ Cell _____
Sex: ◯ Male ◯ Female ◯ Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed
Birth Date _____ Soc Sec _____ Drivers Lic _____
EMAIL _____ ☐ I would like to receive corrospondences via email ☐ Text
Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party Family Physician: _____

Responsible Party (if someone other than the patient)

First Name _____ Last Name _____ Middle Initial _____
Address _____ Address 2 _____
City, State, Zip _____ Pager _____
Home Phone _____ Work Phone _____ Ext _____ Cell _____
Birth Date _____ Soc Sec _____ Drivers Lic _____
◯ Primary insurance policy holder ◯ Secondary insurance policy holder

Emergency Contact

Name _____ Relation _____ Street Address _____
City, State, Zip _____ Home Phone _____ Cell _____

Primary Insurance Information

Name of Insured _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other
Insured Soc Sec _____ Insured Birth Date _____ ID# _____ Group# _____
Employer _____ Ins Company _____

Secondary Insurance Information

Name of Insured _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other
Insured Soc Sec _____ Insured Birth Date _____ ID# _____ Group# _____
Employer _____ Ins Company _____

Dental History

Please check any of the following that apply to you:	**Yes**	**No**
Sensitivity (hot, cold, sweet)	☐	☐
Where? UR LR UL LL		
Headaches, ear aches, neck or joint pain	☐	☐
Mouth ulcers or cold sores	☐	☐
Teeth or fillings breaking	☐	☐
Grinding or clenching of teeth	☐	☐
Bleeding, swollen or irritated gums	☐	☐
Loose, tipped or shifting teeth	☐	☐
Bad breath		
Do you have or have you had any of the following?		
Braces	☐	☐
Gum treatments	☐	☐
If you could whiten your teeth affordably, would you?	☐	☐
Do you smoke or chew tobacco?	☐	☐
How much? For how long?		

On a scale of 1-10 with 10 being the highest rating:
How important is your dental health to you? _____

If I could change my smile, I would:	**Yes**	**No**
Make my teeth whiter	☐	☐
Make my teeth straighter	☐	☐
Close spaces	☐	☐
Replace metal fillings with tooth colored restorations	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Replace old crowns that don't match	☐	☐
Have a smile makeover	☐	☐

Name of previous dentist _____
City, State _____ Phone _____
Why did you leave? _____
What is the most important thing to you about your future smile and dental health? _____
What is the most important thing to you about your dental visit today?
_____

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fee incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Signature (Parent of Child) _____ Date _____ Doctor Initials _____