REGISTRATION AND TREATMENT

PATIENT INFORMATION

Name _____ (LAST / FIRST / MIDDLE IN.) Soc. Sec. # _____

Address _____ E-Mail _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Sex ❑ M ❑ F Age_____ Birth Date_____ ❑ Single ❑ Married ❑ Widowed ❑ Child ❑ Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____ (LAST / FIRST / MIDDLE IN.)

Relation to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Co. & Address _____ Group # _____

SECONDARY INSURANCE

Person Responsible for Account _____ (LAST / FIRST / MIDDLE IN.)

Relation to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Co. & Address _____ Group # _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of Last Dental Care _____ Date of Last Dental X-Rays _____

Check (✔) if you have had problems with any of the following.

❑ Bad Breath
❑ Bleeding Gums
❑ Clicking Or Popping Jaw
❑ Food Collection Between Teeth
❑ Grinding Teeth
❑ Loose Teeth Or Broken Fillings
❑ Periodontal Treatment
❑ Sensitivity To Cold
❑ Sensitivity To Hot
❑ Sensitivity To Sweets
❑ Sensitivity When Biting
❑ Sores Or Growths In Your Mouth

How often do you floss? _____ How often do you brush? _____