Beaverton DENTAL CENTER

PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ _____ _____ _____ Soc. Sec. No._____
LAST NAME FIRST NAME NICKNAME M.I.

Address _____

City_____ State _____ Zip Code _____ Home Phone (_____)_____

Date of Birth_____ Age _____ Sex **M F** Marital Status **S M D W** ____ Cell Phone (_____)_____
MM/DD/YYYY

Employer Name _____ Work Phone (_____)_____ ext. _____

Whom may we thank for referring you? _____ Phone (_____)_____

Specialist (❑ Ortho ❑ Endo ❑ Perio ❑ Other) _____ Phone (_____)_____

Primary Care Doctor _____ Phone (_____)_____

Pharmacy Name/Location _____ Phone (_____)_____

PERSON RESPONSIBLE FOR PAYMENT (PERSON SIGNING FINANCIAL AGREEMENT)

Name _____ Relationship to Patient_____ Soc. Sc. No._____

Date of Birth_____ Address (If Different)_____ City_____ State_____ Zip Code_____
MM/DD/YYYY

Home Phone (_____)_____ Employer_____ Work Phone (_____)_____ Cell (_____) _____

SPOUSE OR PARENT (IF minor, parent other than listed above)

Name _____ Relationship to Patient_____ Soc. Sc. No._____

Date of Birth_____ Address (If Different)_____ City_____ State_____ Zip Code_____
MM/DD/YYYY

Home Phone (_____)_____ Employer_____ Work Phone (_____)_____ Cell (_____) _____

EMERGENCY CONTACT (OTHER THAN LISTED ABOVE)

Name _____ Relationship to Patient_____ Phone (_____)_____

Address _____ City_____ State_____ Zip Code_____ Work Phone (_____)_____ ext. _____

DENTAL INSURANCE (NEED copy of card)

Primary Insurance _____ Employer Name _____ roup No. _____ ID No. _____

Subscriber Name _____ Relationship to Patient_____ Subscriber's Date of Birth _____
MM/DD/YYYY

Insurance Co. Address _____ City _____ State _____ Zip Code _____ Phone (_____)_____

Secondary Insurance _____ Employer Name _____ Group No. _____ ID No. _____

Subscriber Name _____ Relationship to Patient_____ Subscriber's Date of Birth _____
MM/DD/YYYY

Insurance Co. Address _____ City _____ State _____ Zip Code _____ Phone (_____)_____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist & Address _____

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

How often do you floss? _____

How often do you brush? _____

Please check if you have had problems with any of 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 Mouth

COMMUNICATION BY E–MAIL

Do you authorize our office to contact you by e–mail? Y☐ N☐

E–Mail _____

Preferred Method of Communication for Reminders:

Phone☐ Text☐ Email☐ All☐ Other☐

Note: We utilize e–mail for general purposes only. We do not discuss clinical issues via e–mail.

X _____

Signature of Patient (or parent/guardian, if minor)

X _____ _____ _____

Name of person completing this form (Please Print) Relationship to patient Date MM/DD/YYYY