PATIENT REGISTRATION

PATIENT INFORMATION:

Today's Date:___________________________

Home Phone #__________________________ Cell Phone #___________________Work Phone #___________________ Ext #______

E-mail Address:____Preferred Reminder: Text____ Email____ Phone____

Name_______________________________________ I prefer to be called_____________________Birthdate_______________

Address_______________________________________City___________________________State__________Zip______________

Employer______________________________________Soc.Sec.#______________________

Sex_____Marital Status: S___M___W___D___ Spouse's Name__________________________Spouse's Birthdate_____________

Spouse employed by____Spouse Soc.Sec.#_______________________________________

Whom may we thank for referring you?____

If Patient Is A Minor:

Name of Responsible Party____ Relationship to Patient____________________Birthdate____________

Address____City__________________________State___________Zip_____________

Home Phone #_________________________ Cell Phone #___________________SS #____

INSURANCE INFORMATION:

(Please provide a copy of your insurance card)

Primary Insurance:

Name of Insured__________________________________Employer_____________________________Soc.Sec.#___________________

Name of Dental Insurance Co.____Group #________________________________

Secondary Insurance:

Name of Insured__________________________________Employer_____________________________Soc.Sec.#___________________

Name of Dental Insurance Co.____Group #________________________________

Dental History:

Reason for visit?____ Date of last dental visit:___________________

Do you wear dentures or paritals?_________________

Have you noticed:

Bleeding gums? ________ Sensitive Gums? ________ Tired Jaws? ________ Night Grinding? ________ Lost Filling? ________

Would you like a brighter smile? ________

OVER