

**PATIENT REGISTRATION**

Date of Birth: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_

(If Child, Parent's Name) \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer's Name \_\_\_\_\_

Spouse/Emergency Contact Name \_\_\_\_\_ Ph.No. \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Reason for your visit today? \_\_\_\_\_ Last dental visit? \_\_\_\_\_

Did you see your former dentist regularly? \_\_\_\_\_ Or when something bothered you? \_\_\_\_\_

Do you any dental fears? \_\_\_\_\_ If yes, why? \_\_\_\_\_

Are your teeth sensitive to heat? \_\_\_\_\_ Cold? \_\_\_\_\_ Sweets? \_\_\_\_\_ Do your gums bleed? \_\_\_\_\_ Are your gums

Sore? \_\_\_\_\_ Do you have popping, clicking, or snapping noises when you open/close mouth? \_\_\_\_\_

**\*We are a fee for service practice. Payment is due at the time of appointment. As a service to you, we will happily file your insurance for you, for your reimbursement. Please provide the information below.**

Name/Signature of Responsible Party: \_\_\_\_\_ / \_\_\_\_\_

Insurance company: \_\_\_\_\_ Ph. No. \_\_\_\_\_

Claim Address: \_\_\_\_\_ Ins. Employer \_\_\_\_\_

Insured's home address: \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_