REGISTRATION AND TREATMENT

PATIENT INFORMATION

Name: _____ Soc. Sec. #: _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

Home Phone: _____ Cell Phone: _____

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Child ☐ Divorced

Whom may we thank for referring you? _____

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

PRIMARY INSURANCE

Personal Responsible for Account: _____

Relation to Patient: _____ Birthdate: _____ Soc Sec. #: _____

Address (if different than patient): _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed By: _____ Business Phone: _____

Insurance Co. & Address: _____ Group #: _____

SECONDARY INSURANCE

Personal Responsible for Account: _____

Relation to Patient: _____ Birthdate: _____ Soc Sec. #: _____

Address (if different than patient): _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed By: _____ 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 ☐ Grinding Teeth ☐ Sensitivity to Heat ☐ Loose teeth ☐ Broken Fillings ☐ Sensitivity to sweets ☐ Clicking or popping jaw ☐ Periodontal Treatment ☐ Sensitivity when biting ☐ Food Collection between teeth ☐ Sensitivity to Cold ☐ Sores or Growths in your mouth

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