Registration and Dental History

Patient's Name (First): (Last): (Middle Initial):

Preferred Name: Date of Birth: Age: Sex: **MALE FEMALE**

Address : City, State, Zip:

Cell Phone#: Work #: Other #:

E-Mail: Best Contact: **EMAIL TEXT CELL HOME**

Social Security#: Driver's License #:

Marital Status: **SINGLE MARRIED WIDOWED SEPARATED DIVORCED**

Spouse's Name or (If a minor) Parent's Name:

Spouse's Work Phone: Cell #:

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (if different from patient): Relationship:

Responsible Party Address, City, State, Zip:

Home Phone#: Work #: Cell #:

Employer: Employer Address:

INSURANCE & EMPLOYER INFORMATION

Insurance Carrier Name:

Subscriber's Name: Subscriber's Date of Birth:

Relation to Patient: **SELF SPOUSE CHILD OTHER** Subscriber's Phone #:

Subscriber's SS#: Insurance ID #: Group #:

Insurance Carrier Address, City, State, Zip:

Medicaid #:

Employment Status: **FULL TIME PART TIME UNEMPLOYED** Student Status: **FULL TIME PART TIME**

Employer: Phone #:

Employer Address, City , State, Zip:

DENTAL INFORMATION

Do your gums bleed when you brush? **YES NO Don't Know**

Have you ever had orthodontic (braces) treatment? **YES NO Don't Know**

Are your teeth sensitive to cold, hot, sweets or pressure? **YES NO Don't Know**

Do you have earaches or neck pains? **YES NO Don't Know**

Have you had any periodontal (gum) treatments? **YES NO Don't Know**

Do you wear removable dental appliances? **YES NO Don't Know**

How do you feel about the appearance of your teeth?

If you have a current dental problem, how would you describe it?

What was the name of your previous dentist? Office#:

Date of your last dental exam: Date of your last dental x-rays:

What was done at that time?

EMERGENCY CONTACT

Emergency Contact: Phone/Cell #:

(Please list closest relative or friend whose address is different from yours)

Relationship to Patient:

Emergency Contact Address, City, State, Zip:

Preferred Pharmacy: Phone #:

OTHER

How did you hear about us?

Have you or another member of your family been treated here? If so, who?

Would you like to receive appointment reminders via text messages; **YES NO** via email? **YES NO**