DENTAL REGISTRATION

ABOUT YOU

Patient Name: _____ SS# _____-_____-_____

Street Address: _____City_____State_____Zip_____

Home Phone: _____Work #: _____Cellphone: _____

Email Address: _____

Sex ☐ M ☐ F Date of Birth____/_____/_____ ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employer Name: _____ Address: _____

Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

DENTAL INSURANCE: INSURED-CARDHOLDER

Primary Subscriber Name: _____ SS#____-____-_____Date of Birth____/____/____

Address: _____City_____State_____Zip_____

Employer: _____ Address: _____

Insurance Company: _____ ID# _____

Group# _____

Is there secondary Dental insurance? If so, complete the following:

Subscriber's name_____ Date of Birth: _____

Insurance Company: _____ ID# or SS#_____

Group #: _____ Employer: _____

I authorize release of any information regarding my treatment to my insurance company.

_____ _____

Patient or Subscriber (if present) Date

EMERGENCY CONTACT INFORMATION

Name: _____Relationship_____

Home Phone: _____ Work Phone: _____

Reason for today's visit: _____

General Dentist: _____

Place a mark on "yes" or "no" to indicate if you currently have had any of the following:

Burning Sensation on tongue	□ y □ n	**Mouth pain, brushing**	□ y □ n	**Chew on one side of mouth**	□ y □ n
Clicking or popping jaw	□ y □ n	**Pain around ear**	□ y □ n	**Grinding teeth**	□ y □ n
Sensitivity to cold	□ y □ n	**Sensitivity to hot**	□ y □ n	**Sensitivity to sweets**	□ y □ n
Sensitivity when biting	□ y □ n	**Swollen/Tender gums**	□ y □ n	**Jaw Pain or tiredness**	□ y □ n
Loose teeth or broken fillings	□ y □ n				