# *Patient Registration*

DATE _____

**PATIENT NAME** _____ Male____ Female____

Nickname_____ Birth Date _____

Street Address_____ SS#_____

Mailing Address_____ Employer_____

City, State, Zip_____ Occupation_____

Home Phone _____ Cell _____ Text ( YES NO )

Work _____ Ext _____ Email address _____

***Best Way To Contact You:*** 1st_____ 2nd _____ 3rd _____

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***PERSON RESPONSIBLE FOR THIS ACCOUNT IF OTHER THAN PATIENT:*** *( Self Mother Father Guardian )*

Name_____ Birth Date_____

Address_____ Phone_____

Mother_____ Cell_____ Work_____

Father_____ Cell_____ Work_____

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***DENTAL INSURANCE***

Subscriber_____ DOB _____ ID# _____

Employer/Group # _____ Insurance Co _____

Address _____ Customer Service # _____

***2nd COVERAGE***

Subscriber_____ DOB _____ ID# _____

Employer/Group # _____ Insurance Co _____

Address _____ Customer Service # _____

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***EMERGANCY CONTACT – other than your spouse*** _____ (Spouse___ Relative____ Other____)

Phone_____ Address_____

**REFERRED BY**: Existing Patient_____ / Best DDS / Newspaper / Web Page / Phone Book / FB / Google / Yelp / Other _____

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***DENTAL HISTORY***

Chief dental complaint _____

Date of last exam _____ Date last x-rays were taken _____

Previous dentist _____ City _____

Do you have any of the following?

____Sensitive teeth
____Bleeding gums
____Bad breath
____Unpleasant taste
____Food impaction
____Periodontal treatment
____Orthodontic treatment
____Oral Surgery
____Facial injury
____Clenching or grinding
____Loosening of teeth
____Sinus trouble
____Pain around ear
____"popping" or "locked" jaw