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 ___________________

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

Name____ Birth Date____________________

Address____ Phone_________________________

Mother________________________ Cell__________________ Work_________________________

Father_________________________ Cell__________________ Work_________________________

DENTAL INSURANCE

Subscriber_________________________ DOB __________ ID# __________________________

Employer/Group # ___________________ Insurance Co ________________________________

Address __________________________ Customer Service # ____________________________

2nd COVERAGE

Subscriber_________________________ DOB __________ ID# __________________________

Employer/Group # ___________________ Insurance Co ________________________________

Address __________________________ Customer Service # ____________________________

EMERGENCY 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 ________

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